



Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age _____ Sex M or F

Soc. Sec. # _____ Please Circle One: Single Married Separated Widow Mailing

Address _____ City _____ State _____ Zip Code _____

Email _____ Home Phone (_____) _____ Cell Phone (_____) _____

Driver's License # _____ Employer _____

WorkPhone (_____) _____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (_____) _____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (_____) _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us? ☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/Friend/Coworker

☐ Other _____ Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental Insurance Information (Secondary Coverage)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

Please share the following dates:

Your last cleaning ____/____/____ Your last oral cancer screening ____/____/____ Your last complete X-rays ____/____/____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

Name of your previous dentist _____