DENTAL DESIGN

PATIENT REGISTRATION

Patient Name _____ Birth Date _____

Patient's Social Security # _____ Marital Status _____

Name of Spouse/ Parents _____

Patient's Address _____

City, State ZIP _____ Phone # _____

E-mail Address _____

Patient Employed by _____ Work # _____

Business Address _____

Spouse/Parent Employed by _____

Business Address _____ Phone # _____

Person Responsible for Account _____ SS# _____

Address if Different From Patient _____

Dental Insurance Information

Name of Primary Carrier _____ Policy/Group # _____

Insured's Name _____ Birth date _____

Insured's Employer _____ Insured's SS# _____

Name of Secondary Carrier _____ Policy/Group # _____

Insured's Name _____ Birth date _____

Insured's Employer Insured's SS# _____

Whom may we thank for referring you? _____

Nearest relative not living with you? *Name:* *Address:*

Dental History

How long has it been since you have seen a dentist? _____

Are you having problems now? _____ If so, what _____

	YES	NO		YES	NO
Do you wear dentures? Full or Partial?	☐	☐	Are your teeth sensitive to sweets?	☐	☐
If yes, since when Upper _____ Lower _____			Are you unhappy with the appearance of your teeth?	☐	☐
Have you had a bad dental experience?	☐	☐	Are you aware you grind or clench your teeth?	☐	☐
Are you apprehensive about dental treatment?	☐	☐	Do you have headaches, earaches or neck pains?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	Have you had braces (orthodontics)?	☐	☐
Do your gums bleed or feel irritated or swollen?	☐	☐	Do you have discolored teeth that bother you?	☐	☐
Are your teeth sensitive to temperature change?	☐	☐	Would you like your smile to look better?	☐	☐
Are your teeth sensitive to biting?	☐	☐	Do you have problems with dental floss breaking?	☐	☐

I understand that I am personally responsible for payment for all professional services rendered. Although arrangements may be made to assign benefits, this is a courtesy extended to me and I am responsible for the amount unpaid by the insurance carrier.

A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

_____ _____

Patient's Signature *Date*