PATIENT REGISTRATION

DENTAL DESIGN

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 _____

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

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*