Patient Registration

Patient's name _____ Date of Birth_____

Sex: Male/Female If minor, name of legal guardian_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Mailing address: _____ City_____ State____ ZIP_____

Employer_____

Spouse/Parent Name _____ Employer_____ DOB_____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ☐ Not Covered by Dental Insurance ☐ In-Office Membership Plan

PRIMARY DENTAL INSURANCE

Subscriber: ☐ Self ☐ Spouse ☐ Parent Name_____ DOB_____

Subscriber SS# _____ or Member/Subscriber ID # _____

Dental Insurance Co._____ Group#_____ Ph#_____

Claims Address: _____

SECONDARY DENTAL INSURANCE

Subscriber: ☐ Self ☐ Spouse ☐ Parent Name_____ DOB_____

Subscriber SS# _____ or Member/Subscriber ID # _____

Dental Insurance Co._____ Group#_____ Ph#_____

Claims Address: _____

MEDICAL INSURANCE

Subscriber: ☐ Self ☐ Spouse ☐ Parent Name_____ DOB_____

Medical Insurance Co. _____ Subscriber ID#_____ Group#_____

Claims Address: _____

New Patient Dental Questionnaire

How did you hear about our office? _____

Date of last dental cleaning visit_____ Previous dentist_____

Why are you switching dentists? _____

What concerns you most about your mouth?_____

What is important to you when you receive dental care?_____

How often do you brush your teeth? _____ Floss? _____

What do you sip or snack during the day? Ex: (coffee, water, tea, soda, sports drinks, juice, candy, mints)

_____

Do you smoke, vape or use tobacco? _____ How long? _____

Do you have missing teeth?_____How long? _____

Are you happy with the color of your teeth? _____

Are you aware of clenching or grinding? _____ If yes, do you wear a guard?_____

Have you ever had orthodontics (braces)? _____

Have you ever had retainers, partials, dentures or night guard?_____ How long?_____

Did you bring these items with you today? _____