DENTAL REGISTRATION

PATIENT INFORMATION

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Sex: ☐ Male ☐ Female

Birthdate ______________________________

Social Security Number ______________________________

Occupation ______________________________

Employer ______________________________

Home Number ______________________________

Work ____________________ Ext__________

Mobile Phone ______________________________

Email ______________________________

Best time and place to reach you ____________________

SIGNIFICANT OTHER INFORMATION

Spouse's Name ______________________________

Birthdate ______________________________

Social Security Number ______________________________

Employer ______________________________

Occupation ______________________________

Work Number ____________________ Ext __________

Mobile Number ______________________________

Email ______________________________

EMERGENCY CONTACT

(someone who does not live in your household)

Name ______________________________

Relationship to you ______________________________

Home Phone ______________________________

Work Phone ______________________________

Mobile Phone ______________________________

INSURANCE

Primary Subscriber's Name ______________________________

Insurance Company ______________________________

Secondary Subscriber's Name ______________________________

Insurance Company ______________________________

WHO MAY WE THANK FOR REFERRING YOU?

Name: ______________________________

Phone Number: ______________________________

I attest that everything noted above and on the following health histories is true and correct, to the best of my knowledge. Additionally, I accept full financial responsibility for all dentistry performed on me in this dental office. I understand that it is up to me to confirm insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee the insurance status in any of these areas.

Signature ______________________________

Date ______________________________

BLOOD PRESSURE (to be completed by our staff)					
Date: / /	Date: / /	Date: / /	Date: / /	Date: / /	Date: / /
BP: /	BP: /	BP: /	BP: /	BP: /	BP: /

UPDATES

1. Have you had any changes in your medications since your last visit? ☐YES ☐ NO

If yes, please list: ____

2. Have you undergone any surgery since your last visit? ☐YES ☐ NO

If yes, please list surgery and date: ____

3. Have you been diagnosed or treated for any new medical issues since your last visit? ☐YES ☐ NO

If yes, please list: ____

____

Signature ***Date***

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If yes, please list: ____

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If yes, please list surgery and date: ____

3. Have you been diagnosed or treated for any new medical issues since your last visit? ☐YES ☐ NO

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Signature ***Date***