PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

GUARDIAN NAME: _____

GUARDIAN #: _____

SPOUSE'S WORK #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

PATIENT NAME _____ Birth Date _____

How Did You Hear About Us?

Qwestdex Yellow pages:	☐	Yellowbook Yellow pages:	☐
Received flyer in mail:	☐	Billboards:	☐
Dental health meeting:	☐	Web site:	☐

Family member _____

Friend _____

Insurance Company _____

Other _____

*When you refer two people outside of your immediate family, we'll give you one free take home whitening kit, valued at $350, which includes your personalized trays and four tubes of gel. That's our way of saying "Thank You".

DENTAL HISTORY

Please answer the following questions, so we can provide you with the best dental care.

How Often Do You Brush? _____ Toothpaste: _____
How Often Do You Floss? _____ Mouthwash: _____
Other:

Is there anything you would change about your smile? _____

_____

When was your last dental visit? _____

_____

What was the dental visit for? _____

Please circle the answer that pertains to your dental history:

Are Your Teeth Sensitive To:

Hot or Cold:	Present	Past	Never
Biting/Chewing:	Present	Past	Never
Sweets:	Present	Past	Never

Have You Ever Had:

Orthodontic Treatment:	Present	Past	Never
A bite plate or guard:	Present	Past	Never
Periodontic Treatment:	Present	Past	Never
Oral Surgery:	Present	Past	Never
Serious injury to mouth or head:	Present	Past	Never