



Today's
Date: _____

Registration Form

New Patient Information [Referring Physician] _____ Updated Patient Information

How did you hear of us: News Radio Billboard Friend/Relative Website Other _____

Patient Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth ___/___/___ Social Security # _____ Phone # _____

Cell Phone #: _____ Email Address: _____

Male Female Marital Status: Single Married Divorced Widowed Maiden Name _____

In Case of Emergency Contact _____ Phone _____

Person responsible for the bill; if other than patient: Relationship to Patient: Self Spouse Child Other

Last Name _____ First Name _____

Date of Birth ___/___/___ Social Security # _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Guarantor Last Name _____ First Name _____

Date of Birth ___/___/___ Guarantor Social Security # _____ Phone # _____

Patient Relationship to Guarantor: Self Spouse Child Other

Address _____ City _____ State _____ Zip _____

Employer _____ Employer Address _____

Primary Insurance Carrier Name: _____ Billing ID # _____

Secondary Insurance Carrier Name: _____ Billing ID # _____

This confidential data is not reported on an individual basis.

Household Income

My Annual household Income is: _____ How many people are in your household: _____

Race/Ethnicity

Asian Black/African American [not Hispanic] White [not Hispanic]
 Unreported/Unknown Pacific Islander American Indian/Alaska Native
 Hispanic [all races] Need Interpretation Services [Bilingual]



Today's Date: _____

Health Questionnaire

Patient Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Social Security # _____ Phone # _____

In Case of Emergency Contact _____ Phone _____

If you are completing this form for another person, what is your relationship to this person? _____

Please Answer Each Question

1. Are you under the care of a medical doctor? YES NO
2. Are you currently taking any medicine or drugs? YES NO
If so, please list them: _____
3. Are you allergic to or made sick by: latex, penicillin, codeine, aspirin or any other drugs or medicines? YES NO
If yes please list them: _____
4. Have you ever had a bleeding problem requiring special treatment: YES NO
5. (Women) Are you pregnant now? YES NO If yes, what month? _____
6. Do you wear a pacemaker? YES NO
7. Check any of the following which you have now, or have had in the past.

Alcoholism	Epilepsy	Jaundice	Rheumatic Fever
Anemia	Heart Murmur	Kidney Disease	Sinus Trouble
Artificial Heart Valve	Heart Trouble	Mental Retardation or	Stroke
Asthma	Hepatitis	Developmental Disorder	Thyroid Disease
Diabetes	High Blood Pressure	Prolapsed Mitral Valve	Tuberculosis
Emphysema	HIV / AIDS	Psychiatric Treatment	Other

8. List any other health problems _____

Physician's Name _____ Phone _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or my medicines change, I will inform the dentist at the next appointment.

Signature of patient or Parent/Guardian (if minor)

Signature of Dental Provider