Registration and Treatment

smiles dental

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last First MI

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Sex ☐ M ☐ F Age _____ DOB _____ ☐ Single ☐ Married ☐ Child

Patient Employer _____ Occupation _____

Employer Address _____ Employer Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last First MI

Relationship to Patient _____ DOB _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Responsible Party Employer _____ Occupation _____

Employer Address _____ Employer Phone _____

Insurance Co. & Address _____ Group # _____

SECONDARY INSURANCE

Person Responsible for Account _____
Last First MI

Relationship to Patient _____ DOB _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Responsible Party Employer _____ Occupation _____

Employer Address _____ Employer Phone _____

Insurance Co. & Address _____ Group # _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Date of Last Dental Care _____ Date of Last Dental X-Rays _____

Check if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity to Sweets
☐ Clicking or Popping Jaw	☐ Periodontal Treatment	☐ Sensitivity when Biting
☐ Food Collection Between Teeth	☐ Sensitivity to Cold	☐ Sores or Growths in your Mouth

How often do you floss? _____ How often do you brush? _____