PATIENT REGISTRATION

Mr. Mrs. Ms. Dr. Full name____ Date____________________________

Phone (Home) (____) _______ ___________ (Work) (_____) ________ ________ (Cell) (____) ________________

Address ____

City _________________ State __________ Zip ___________ Email _______________________________________

Date of Birth ___/_____/_____ Social Security ____ - ______ - _________ Drivers License # ___________________

Marital Status ___________ Spouse Name ______________________Occupation ___________________________

Employer ____ Work Hours ______________

Contact in case of Emergency ___________________________________ Phone (______) _______ - ____________

Have you ever been a patient of our practice? Yes No

Referring Dentist ____ Phone (_____) _______ - ____________

Medical Doctor ____ Phone (______) ________ - _____________

When was your last dental appointment? ____

Person responsible for your dental investment____

Purpose of My Visit is to Discuss

Removal of wisdom teeth	Yes	No
Dental Implants	Yes	No
TMJ problems	Yes	No
Cosmetic Enhancements		
• Eyelid surgery	Yes	No
• Brow lift surgery	Yes	No
• Facelift surgery	Yes	No
• Neck lift surgery	Yes	No
• Skin treatments (botox, chemical peel, laser resurfacing)	Yes	No
• Chin /cheek enhancements	Yes	No
• Sun/age spots	Yes	No
• Facial scars	Yes	No
• Facial liposuction	Yes	No
• Other	Yes	No

For Insurances Purposes

Name of policy holder ______________________________ Policy holder's social security # _____ - _____ - ________

Policy holder's date of birth _________________________________ Employer_________________________________

Name of the insurance company________________________ Insurance company's phone _____________________

Group # ______________________ Ins. Co. Address ____

Are you covered by another plan? If so please complete the following….

Name of the policy holder _________________________ Policy holder's social security #______ - ______ -________

Policy holder's date of birth ________________________ Employer____

Name of the insurance company______________________ Insurance company's phone _______________________

Group # __________________ Ins. Co. Address ____