PATIENT REGISTRATION

Patient Information:

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

Preferred Name:_____ Birth Date:_____ Age:_____ SSN#:_____

Please Circle: Male Female Please Circle: Married Single Divorced Widowed

Address:_____City:_____State:_____Zip:_____

Cell Phone:_____ Work:_____ Home:_____

_____YES, Please sign me up for text reminders about my appointments

_____YES, Please sign me up for e-mail reminders E-mail:_____

Emergency Contact:_____ Phone#:_____ Relationship to patient:_____

Responsible Party: (must be adult 18+yrs old that is signing papers; can not list another adult as resp. party)**

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

Birth Date:_____ SSN#:_____ (required if we are filing dental benefits)

Address:_____City:_____State:_____Zip:_____

Relationship to patient (Please Circle): Parent Spouse Other

DENTAL HISTORY

Do you have any of the following concerns?	Yes	No
Tooth Pain		
Tooth Sensitivity		
Jaw Joint Pain		
Bleeding/Swollen Gums		
Grinding/Clenching		
Loose/Shifting Teeth		
Broken Teeth/Fillings		
Bad Breath		
Snoring/Sleep Apnea		

If I could change my smile, I would: (Check all that apply)

____Straighten Teeth

____Whiten Teeth

____Close Spaces

____Replace Silver Fillings

____Replace Old Crowns

____Replace Missing Teeth

____Replace Old Partial/Denture

____Have A Smile Makeover

How did you hear of our office? _____

Name(print):_____Signature:_____Date:_____

LEGACY FAMILY DENTAL