



# Smile

# Dental

# Registration

## PATIENT INFORMATION

Date \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

First Name Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## DENTAL INFORMATION

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath  Yes  No

Bleeding gums  Yes  No

Blisters on lips or mouth  Yes  No

Burning sensation on tongue  Yes  No

Chew on one side of mouth  Yes  No

Cigarette, pipe, or cigar smoking  Yes  No

Clicking or popping jaw  Yes  No

Dry mouth  Yes  No

Fingernail biting  Yes  No

Food collection between the teeth  Yes  No

Foreign objects  Yes  No

Grinding teeth  Yes  No

Gums swollen or tender  Yes  No

Jaw pain or tiredness  Yes  No

Lip or cheek biting  Yes  No

Loose teeth or broken fillings  Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Mouth breathing

Mouth pain, brushing

Orthodontic treatment

Pain around ear

Periodontal treatment

Sensitivity to cold

Sensitivity to heat

Sensitivity to sweets

Sensitivity when biting

Sores or growths in your mouth

How often do you floss? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

