PREMIER Dental Care

Patient Registration

Patient Information

First Name _____ Middle Initial_____ Last Name_____ Date_____

Date of Birth _____Age_____ E-mail address _____

Home Phone _____ Cell Phone _____Work Phone_____

Social Security # _____ Driver's License _____

Address _____

City _____ State _____ Zip _____

Marital Status: __Single __Married __Divorced __Widowed __Separated

Employer_____

Employer Address _____ Employer Phone # _____

Emergency Contact _____ Relationship _____ Phone_____

How did you hear about us?

____Insurance Provider List ____Online ____Radio ____www.smilebr.com ____Another Doctor
____Social Media ____Magazine ____Sign in front of office ____ T.V. Commercial
___ Family/Friend - - - Whom can we thank for referring you?_____

Insurance

Primary Dental Insurance

Subscriber _____

Relationship to patient _____

Date of Birth_____ SS# _____

Employer _____

Work Phone _____

Insurance Company _____

Ins. Phone #_____

Group # _____

Secondary Dental Insurance

Subscriber _____

Relationship to patient _____

Date of Birth_____ SS# _____

Employer _____

Work Phone _____

Insurance Company _____

Ins. Phone #_____

Group # _____

Dental History

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning_____

Last Full Mouth X-rays _____ Previous Dentist's Name _____

Address _____ Telephone _____

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

Have you ever used or are currently using topical fluoride? Yes No

Are you extremely fearful of the dentist? Yes No

Are you happy with the appearance of your smile? Yes No

Is there anything about your smile you would like to change? (shape, color, alignment) Yes No

If yes, please explain _____