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