Engineered Smiles

Patient Registration

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

Preferred Name: _____ Occupation: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ ZIP: _____

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Social Security No.: _____ Date of Birth (MM/DD/YYYY): _____

□Male □Female Marital Status: □Married □Single □Divorced □Separated □Widowed

Email (for patient communication only): _____

INSURANCE SUBSCRIBER INFORMATION

Insurance Company: _____ Employer: _____

Member ID: _____ Group #: _____

POLICYHOLDER INFORMATION (if different from the patient)

Policyholder Name: _____ SSN: _____ DOB: _____

Phone: (_____)_____ Relationship to Party: _____

Address: _____ City/State/ZIP: _____

EMERGENCY CONTACT

Name: _____ Phone: (_____)_____ Relationship: _____

WHOM MAY WE THANK FOR YOUR REFERRAL TO US?

□Drive-By □Google □Insurance search □Facebook □Internet search □Yelp

□Family/Friend: _____ □Other: _____

DENTAL HISTORY

What are your dental concerns/expectations: _____

When was your last dental visit: _____ When was your last dental cleaning: _____

Have you avoided regular dental care: Y / N Do you think you have active decay: Y / N

Do you experience bad breath: Y / N Do your gums bleed easily: Y / N

Have you had a previous bad dental experience: Y / N If yes, describe: _____

How often do you brush: _____ How often do you floss: _____

Are you happy with the appearance of your teeth: Y / N Would you like your teeth to be whiter: Y / N

When it comes to dental treatment, are you:

□**Proactive** (Treat something before it becomes a larger, more costly problem)

□**Reactive** (Treat something only when it bothers you)