# Madison Family Dental Patient Registration

Patients First Name_____Last Name_____MI___

□ Male □ Female □ Minor □ Single □ Married □ Divorced □ Widowed

Address _____City, State, Zip _____

Home Phone_____Cell Phone_____WorkPhone_____

Birth Date_____Social Security Number _____

Employer_____Spouse or Parents Name_____

Contact in case of an EMERGENCY_____Phone Number_____

## Responsible Party *(If Different From Patient)*

Person Responsible For Account_____ Relationship to Patient_____

Address_____Home/Cell Phone_____DOB_____

SSN_____Employer_____Work Phone_____

## Dental Insurance Information

Name of Insured_____Relationship to Patient □ Self □ Spouse □ Child □ Other

Address of Insured_____Birth Date_____

Name of Employer_____Work Phone_____

Insurance Company Name_____Address_____

Insured ID #_____Group #_____

*PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD TO COPY*

Pharmacy Name_____Phone_____

Chief Complaint_____

Last Dental Visit_____ Were X-Rays Taken? □Yes □No

How often do you Brush? _____ x per day Floss?_____ x per day Do you Clench or Grind? □Yes □No

Are your teeth Sensitive? □ Cold □ Hot □ Sweets Do your gums Bleed when you Brush? □Yes □No

WHO MAY WE *THANK* FOR YOUR REFERRAL _____

Address _____ City, State, Zip _____

□ Family □ Friends □ Other Dentist □ Other