



Jane J. Chen D.D.S., PC  
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# PATIENT REGISTRATION FORM

**TODAY'S DATE:** \_\_\_\_\_

**PATIENT NAME:** First \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**E-mail:** \_\_\_\_\_ **Cell Phone:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Home Phone:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Business Phone:**( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Mailing Address:** Street \_\_\_\_\_ Apt# \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Sex:** M F **Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

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

## IN CASE OF EMERGENCY NOTIFY

Name	Address	Home Phone	Cellphone
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## INSURANCE

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_

SSN \_\_\_\_\_ Date employed \_\_\_\_\_ Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Address of employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance company \_\_\_\_\_ Group number \_\_\_\_\_

Insurance company address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have any additional insurance? YES NO Name of Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

## CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

The undersigned hereby authorizes Dr. Chen and staff to perform any diagnostic aids deemed necessary to make a thorough diagnosis of my needs. I also authorize Dr. Chen and staff to perform any and all forms of dental treatment and therapy that may be indicated.

In consideration of treatment rendered the above- named Patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the Patient; however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection cost, interest of 21% APR, court costs and reasonable attorney fees.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

I agree to be contacted by phone, email, fax or U.S. mail to convey information about appointments, lab test results, clarify medication dosages, or answer simple dental or insurance questions. You may leave a message on voice mail.  You may disclose information to following family members and/or non-family members.

Name	Phone Number	Relationship

**Signature (patient, parent or legal guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name (patient, parent or legal guardian)** \_\_\_\_\_







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**GENERAL QUESTIONS:**

Have you ever had any problems or complications with previous dental treatment? ..... YES NO  
 Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO  
 How often do you brush your teeth? 1x/day 2x/day After each meal  
 What kind of toothbrushes do you use? Manual Electric  
 How often do you floss your teeth? 1x/day 2x/day After each meal  
 Have you lost any teeth/have any teeth been removed? ..... YES NO  
 Why? \_\_\_\_\_  
 Have they been replaced? ..... YES NO  
 Are you happy with the replacement? ..... YES NO  
 If no, explain \_\_\_\_\_

**TMJ :**

Do you clench or grind your teeth?.....YES NO  
 Does your jaw click or pop?..... YES NO  
 Have you experienced any pain or soreness in the muscles on your face or around your ear?.....YES NO  
 Do you have frequent headaches, neck pain or shoulder pain? ..... YES NO

**PERIODONTAL DISEASE:**

Do your gums bleed when you brush and floss?..... YES NO  
 Do you feel your breath is offensive at times? ..... YES NO  
 Have you had any periodontal treatments in the past?..... YES NO

**SMILE ANALYSIS:**

Are you interested in a free *Smile Design* Consultation?..... YES NO

**To the best of my knowledge, all of the information provided on both sides of this registration form is correct.**

\_\_\_\_\_  
*Signature of Patient, Parent or Legal Guardian* \_\_\_\_\_  
*Date*