New Patient Registration

Patient Information

Patient Name:_____
Last Name First Name Middle Initial
Birthdate:_____ Soc Sec #_____
Home Address:_____
City/State/Zip Code_____
Male/Female (circle one) Marital Status:_____
Home Phone:_____Cell Phone:_____Work Phone_____

Whom may we thank for referring you?_____

Dental Insurance

Insurance Company_____
Name of Insured_____Relationship to Insured_____
Member ID #_____Group Number_____
Insurance Customer Service Phone#_____
Insured Social Security Number_____Insured Birthdate_____

In case of emergency, Contact (Specify someone who does not live in your household.)
Name:_____Relationship to Patient_____
Phone #_____

Assignment and Release

☐ I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to **Dr. Hitesh Patel** all insurance benefits, if any, otherwise payable to me for services rendered . I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

☐ The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Dental History

Reason for today's visit_____
Former Dentist:_____City/State_____
Date of Last Dental Visit _____Date of last dental x-rays:_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	Yes	No	Burning sensation on tongue	Yes	No
Dry mouth	Yes	No	Clicking or popping jaw	Yes	No
Foreign objects	Yes	No	Chew on one side of mouth	Yes	No
Gums swollen/tender	Yes	No	Cigarette/pipe/cigar smoking	Yes	No
Lip or cheek biting	Yes	No	Loose teeth/broken fillings	Yes	No
Pain around ear	Yes	No	Sensitivity when biting	Yes	No
Sensitivity to cold	Yes	No	Blisters on lips or mouth	Yes	No
Sensitivity to sweets	Yes	No	Sores/growths in mouth	Yes	No
Periodontal treatment	Yes	No	Orthodontic treatment	Yes	No
Bleeding gums	Yes	No	Fingernail biting	Yes	No
Grinding teeth	Yes	No	Jaw pain or tiredness	Yes	No
Mouth breathing	Yes	No	Mouth pain, brushing	Yes	No
Sensitivity to heat	Yes	No	Food collection between the teeth	Yes	No

How often do you brush?

How often do you floss?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Guardian_____
Date_____ Relationship_____