

# BAYSIDE DENTAL CARE

## PATIENT REGISTRATION

(PLEASE PRINT)

DATE \_\_\_\_\_ HOW WERE YOU REFERRED TO OUR OFFICE? \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ NICKNAME \_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_ CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHYSICAL ADDRESS (IF MAILING IS A PO BOX) \_\_\_\_\_

PT HOME PH: \_\_\_\_\_ BUSINESS PH: \_\_\_\_\_ CELL PH: \_\_\_\_\_

PT BIRTHDAY \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ DRIVERS LICENSE # \_\_\_\_\_

*Please present Drivers License to Receptionist*

EMAIL \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE: \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ EMP. PHONE # \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_ SPOUSE BDAY \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

SPOUSE PLACE OF EMPLOYMENT \_\_\_\_\_

CIRCLE APPROPRIATE CHOICE: (CHILD) (SINGLE) (MARRIED) / (MALE) (FEMALE)

*(IF PATIENT IS A CHILD, PARENT/GUARDIAN NEEDS TO FILL OUT RESPONSIBLE PARTY INFORMATION BELOW)*

## RESPONSIBLE PARTY INFORMATION

FULL NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/ST \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PT \_\_\_\_\_

## EMERGENCY CONTACT

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

## DENTAL HISTORY

WHEN WAS YOUR LAST DENTAL VISIT? \_\_\_\_\_

DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS? \_\_\_\_\_

ARE YOU SENSITIVE TO?..... HOT/COLD SWEET/SOUR FOODS/LIQUID

ARE YOU SATISFIED WITH YOUR SMILE? \_\_\_\_\_

WHAT WOULD YOU LIKE TO CHANGE? \_\_\_\_\_

### Agreement to Pay:

The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

Signature \_\_\_\_\_ DATE \_\_\_\_\_