# **Bristol Park Dental Registration Form**

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| **Personal Information** |  | | | |
| Last Name: | | First Name: | | Middle Initial: |
| Preferred Name: | | Date of Birth: | | |
| Gender/Pronoun: | | Email: | | |
| Responsible Party (if other than self): | | Responsible Party’s Relationship to Patient: | | |
| Address: | | City: | | |
| State: | | Zip Code: | | |
| Home Phone: | | Cell Phone : | | |
| Work Phone: | | Employer: | | |
| Emergency Contact Name | | Emergency Contact Relationship to Patient: | | |
| Emergency Contact Phone #: | | Where did you hear about us? | | |
| **Insurance Information** |  |  |
|  | **Primary Dental Insurance** | | **Secondary Dental Insurance** | |
| Insurance Company: |  | |  | |
| Policy Number or SSN: |  | |  | |
| Subscriber’s Name (if other than self): |  | |  | |
| Subscriber’s Relationship to Patient: |  | |  | |
| Subscriber’s Date of Birth: |  | |  | |
| Subscriber’s Employer: |  | |  | |
| Subscriber’s Address (if other than above): |  | |  | |
| **Dental Information** |  | | | |
| Do your gums bleed when you floss? | | Do you have clicking, popping or soreness in your jaws? | | |
| Have you had periodontal (gum) treatments? | | Have you had your teeth straightened? | | |
| When was your last dental exam? | | Do you have sores or ulcers in your mouth? | | |
| When were your last dental x-rays taken? | | Do you grind your teeth? | | |
| Have you had problems with previous dental treatments? | | | | |
| Do you have any concerns about visiting the dentist? | | | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician**. I understand that I am financially responsible for any balance. I understand that, if I don’t have dental insurance, I must pay for all services at the time of treatment.** I also authorize Bristol Park Dental or insurance company to release any information required to process my claims.

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*PLEASE TURN PAGE OVER TO COMPLETE MEDICAL HISTORY FORM\*\*