# **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\*\*