Bristol Park Dental Registration Form

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?	
Social Security Number:		

Insurance Information

	Primary Dental Insurance	Secondary Dental Insurance
Insurance Company:		
Policy Number:		
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