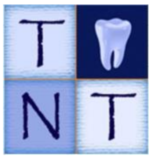

TNT DENTAL CARE

REGISTRATION FORM

Today's Date:________________________

Welcome to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient last name:	First:	MI:	Preferred name:

If minor, parents' names:

Marital status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	Sex ☐ M ☐ F	Birth date:

Patient/Guardian's occupation:	Patient/Guardian's employer:	Work phone:

Other family members seen here:

CONTACT INFORMATION

Address:

City:	State:	Zip code:
Patient social security number:	Home phone:	Cell phone:

Email:

Whom may we thank for referring you?

☐ Yelp ☐ Facebook ☐ Website ☐ Friend ______________________ ☐ Other_________________

When is the best time to contact you? ☐ Morning ☐ Afternoon

PRIMARY INSURANCE INFORMATION

(Please give your insurance card and photo identification card to the receptionist.)

Person responsible for account:	Relationship to patient:

Birth date:	Social security number:	Address (if different from patient's):

Occupation:	Employer:	Business phone:

Insurance Company Name:

Subscriber's name:	Subscriber's birth date:	Subscriber's ID#:	Group #:

ADDITIONAL INSURANCE INFORMATION

Is patient covered by additional insurance? ☐ Yes ☐ No

Person responsible for account:	Relationship to patient:

Birth date:	Social security number:	Address (if different from patient's):

Occupation:	Employer:	Business phone:

Insurance Company Name:

Subscriber’s name:	Subscriber’s birth date:	Subscriber's ID#:	Group #:

DENTAL HISTORY

What would you like us to do for you?	Are you in dental discomfort?	Date of last dental visit:	Phone:

Check if you have had problems with any of the following:

☐ Bad breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growths in mouth
☐ Frequent headaches	☐ Prolonged bleeding after extraction	☐ Orthodontic work	☐ Any head, neck, or jaw injuries

MEDICAL HISTORY

Physician's name:	Phone:	Date of last visit:	Any surgical operation or serious illness?

Women: Are you pregnant? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N Are you taking oral contraceptives? ☐ Y ☐ N

Check whether you have had any of the following:

☐ AIDS/HIV positive	☐ Chemotherapy	☐ Heart Pacemaker	☐ Pain in jaw joints
☐ Anaphylaxis	☐ Cold sores/fever blisters	☐ Hepatitis A	☐ Psychiatric care
☐ Anemia	☐ Congenital heart disorder	☐ Hepatitis B or C	☐ Radiation treatments
☐ Angina	☐ Diabetes	☐ Herpes	☐ Recent Weight loss
☐ Arthritis/Gout	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatic fever
☐ Artificial Heart Valve	☐ Easily Winded	☐ High Cholesterol	☐ Shingles
☐ Artificial Joint	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sinus trouble
☐ Asthma	☐ Excessive bleeding	☐ Irregular heartbeat	☐ Stroke
☐ Blood Disease	☐ Fainting spells/dizziness	☐ Kidney problems	☐ Thyroid disease
☐ Blood transfusion	☐ Frequent headaches	☐ Leukemia	☐ Tonsillitis
☐ Breathing problems	☐ Glaucoma	☐ Liver disease	☐ Tuberculosis
☐ Bruise easily	☐ Heart Attack/Failure	☐ Low blood pressure	☐ Tumors or growths
☐ Cancer	☐ Heart Murmur	☐ Osteoporosis	☐ Tumors or growths

List any allergies:

List any medications currently taking (including any non-prescription):

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone:	Work phone:

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 also authorize TNT Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian signature   Date