

Contemporary Dentistry, PLLC

Arlene Messer, DDS • Anna V. Belous, DDS

PATIENT REGISTRATION

Patient Name _____ Birth Date _____ SS # _____
Spouse's Name _____ Birth Date _____ SS# _____
(If a child) Parent's Name _____ Birth Date _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Ext _____ Cell # _____
Marital Status: Single Married Significant Other Divorced Separated Widowed
Email Address _____
Hobbies/Interests _____
Purpose for this appointment _____
Are any of your family members patients at our practice? _____
Who may we thank for referring you? _____

Responsible Party (if someone other than patient) _____
Address _____ City _____ State _____ Zip _____
Birth Date _____ SS# _____ Driver's License # _____

In case of emergency, who should we contact? _____ Phone # _____
Patient employed by _____ Present position _____
Business address _____ City _____ State _____ Zip _____
Spouse employed by _____ Present position _____
Business address _____ City _____ State _____ Zip _____
Are you a full time student? _____ Name of school _____

Primary Insurance Information:

Name of insured _____ Birth date _____ Relationship to patient _____
Primary insurance company _____ Policy # _____ Group # _____
Address _____ City _____ State _____ Zip _____
Insurance company phone # _____

Secondary Insurance Information:

Name of insured _____ Birth date _____ Relationship to insured _____
Secondary insurance company _____ Policy # _____ Group # _____
Address _____ City _____ State _____ Zip _____
Insurance company phone # _____

Patient Medical/Dental Information:

Name, address, and Phone # of primary physician _____

1. When was your last dental visit? _____	7. Do you get headaches, jaw, neck or shoulder pain, or have you had TMJ issues in the past? Yes No
2. Does dental treatment make you nervous?..... Yes No	8. Do you have or have you ever had any of the following: Please circle what applies
3. Are you having any discomfort at this time?..... Yes No Where? _____	Clicking or popping of jaw..... Yes No
4. Are you interested in whitening your teeth?..... Yes No	Difficulty opening or closing jaw..... Yes No
5. Are you interested in finding out more about cosmetic Dentistry? Yes No	Clenching/grinding/shifting in bite..... Yes No
6. Have you had orthodontic treatment? Yes No	Bleeding or sore gums..... Yes No
	Sensitivity to hot, cold, sweets, or biting..... Yes No