HUGHES DENTAL GROUP
Family and Cosmetic Dentistry

New Patient Registration

Date:_____/_____/_____

Patient Information

PATIENT FIRST NAME:________________________**LAST:**_______________________**INITIAL:**________
DOB:____/____/____ SS#:______-_____-________ Sex: Male: ☐ Female: ☐
Address:__________________________________City:___________________State:______Zip:__________
Cell:(_____)_____-_________ Work:(_____)_____-_________ Home:(_____)_____-_________
Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐
Email:____
Employer:________________________________Spouse's Employer________________________________
Employment Status: Full Time: ☐ Part Time: ☐ Retired: ☐ Student: ☐
IN CASE OF AN EMERGENCY CONTACT:
Emergency Contact:_____________________________________ Phone:(_____)_____-_________

Dental Insurance

Dental Insurance : Yes: ☐ No: ☐ Insurance Company______________________________
Relation to Subscriber: Self:☐ Spouse:☐ Dependent:☐
If not self, Subscriber name:__________________________________ DOB:____/____/____
Employer:______________________________________ Subscriber SS#:______-_____-______
Secondary Insurance:Yes:☐ No:☐ Insurance Company______________________________
Relation to Subscriber: Self:☐ Spouse:☐ Dependent:☐
If not self, Subscriber name:__________________________________ DOB:____/____/____
Employer:_______________________________________ Subscriber SS#:______-_____-______

Assignment and Release:
I authorize release of any information relating to all dental claims an understand that I am responsible for all costs of dental treatment regardless of my insurance coverage. I hereby authorize payment of dental benefits otherwise payable to me directly to Hughes Dental Group.

Signed____Date:____/____/____

Dental History

Reason for today's visit: Cleaning:☐ Exam:☐ Tooth Pain:☐ Other:☐_____________________________
How often do you brush?: 1x/day: ☐ 2x/day:☐ 3+/day:☐ Never:☐
How often do you floss?: 1x/day:☐ 1x/week:☐ 1x/month:☐ Never:☐
Date of last dental visit_______________________
Questions or Concerns for the doctor: None:☐ ____
Mark ☒ if you have had any of the following:

Bad Breath	☐	Food collection between teeth	☐	Orthodontic treatment	☐
Bleeding gums	☐	Grinding teeth	☐	Pain around ear	☐
Blisters on lips	☐	Gums swollen/tender	☐	Periodontal treatment	☐
Burning sensation on tongue	☐	Jaw pain/tiredness	☐	Sensitivity to cold	☐
Chew on one side	☐	Lip or cheek biting	☐	Sensitivity to heat	☐
Cigarette/Pipe/Cigar smoking	☐	Loose teeth/broken filling	☐	Sensitivity to sweets	☐
Clicking/Popping jaw	☐	Mouth breathing	☐	Sensitivity when biting	☐
Dry mouth	☐	Mouth pain	☐	Sores/growths in mouth	☐
Fingernail biting	☐				