New Patient Registration
Hagan Dentistry, P.L.L.C.

1 PATIENT INFORMATION

Date:_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age:_____ Birthdate:_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____
Occupation _____
Employer_____
Employer Phone _____
Spouse's Name _____
Birthdate_____ SS#_____
Occupation _____
Spouse's Employer _____
Name of responsible part (for this account)

_____
Relationship to patient_____
Whom may we thank for referring you _____

2 DENTAL INSURANCE

Name of responsible party for account_____
Relationship to patient_____
Insurance Co._____
Group #_____
Subscriber Name_____
Birthdate_____SS# _____
Relationship to patient_____
Is patient covered by additional Insurance ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Hagan Dentistry, P.L.L.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize Hagan Dentistry, P.L.L.C., to release all the information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible party signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Cell _____ Email _____

Best time and place to reach you between 8:00am – 5 pm _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name:_____Relationship:_____

Home Phone:_____ Work Phone:_____

4 DENTAL HISTORY

Reason for today's visit: _____
_____
Former D.D.S. (Optional)_____
_____
City/State/Phone_____
_____
Date of last dental visit_____
Date of last dental x-rays _____
Place a mark on "yes" or "no" to Indicate If you have, or have had, any of the following:

	Yes	No
Bad breath	☐	☐
Bleeding gums	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Tobacco products: describe	☐	☐
_____	☐	☐
Clicking or popping jaw	☐	☐
Dry mouth	☐	☐
Fingernail biting	☐	☐
Food collection between teeth	☐	☐
Grinding teeth	☐	☐
Gums swollen or tender	☐	☐
Jaw pain or tenderness	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Pain around ear	☐	☐
Periodontal treatment	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐
Sensitivity when biting	☐	☐
Sores or growths in your mouth	☐	☐
How often do you floss	☐	☐
How often do you brush	☐	☐