Bayside Dental
and Orthodontics
YOUR FAMILY DENTIST

2300 7th Street, Bay City,
TX 77414
979-330-4113

PATIENT REGISTRATION FORM:

Patient First Name: _____ Last Name: _____ Middle Initial:____ _____
Preferred Name: _____

Policy Holder/Responsible Party Information:
(For children under 18, parent/legal guardian information belongs here)

First Name: _____ Last Name: _____ Middle Initial:_____
Mailing Address: _____
City, State, and Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Ext #: _____
DOB: _____ Soc. Sec #: (required for insurance billing) _____
Drivers Lic #: _____ Lic. State: _____

Patient Information:

Mailing Address: _____
City, State, and Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Ext #: _____
DOB: _____ Soc. Sec #: (required for insurance billing) _____
Email: _____

Would you like to receive important office news and reminders via email? Y or N

Sex: Male/ Female **Marital Status:** Married/ Single/ Divorced/ Widowed
Employment Status (Full time, part time, retired)? _____
Student Status (Full time, part time)? _____
Emergency Contact information (Name & Numbers): _____
REFERRED BY: _____

(Please continue on the other side)

Primary Insurance Information:

Name of Insured/ DOB:_____
Insured Soc. Sec.#: _____ Member ID #: _____
Relationship to patient: _____
Employer name and address:_____
Ins. Company name and Address:_____

Is there Secondary Insurance Information: Y or N

Secondary Insurance Information:

Name of Insured/ DOB: _____
Insured Soc. Sec.#: _____ Member ID #: _____
Relationship to patient: _____
Employer name & address: _____
Ins. Company name & Address: _____

Please help us become acquainted with your dental history by answering the following questions:

How long ago was your last dental appointment/check-up? _____
How often do you have your teeth cleaned? _____

Are you having any discomfort at this time? Y /N

Where? _____

Do you have any of the following (please circle)?
Bleeding gums unpleasant taste in your mouth bad breath

Do you have history of periodontal (gum) disease? _____
Do you wear dentures? Y/N Date of placement: _____
Do you wear orthodontic braces? Y/N Date treatment started: _____
Do you have a fear of Dentistry? Y/N
If so, why? _____

Please describe your main reason for today's visit, along with any other dental concerns:

_____
_____
_____
_____
_____