Dr. Ben Williams
bWd
Esthetic Dentistry, LLC

DENTAL REGISTRATION

ABOUT YOU

Patient Name: ______________________________ SS# ______-______-______

Street Address: ______________________ City ______________ State ______ Zip ________

Home Phone: ______________ Work Phone: ______________ Cellphone: ______________

Sex: M ❑ F ❑ Date of Birth____/_____/______ ❑ Single ❑ Married ❑ Separated ❑ Divorced

Employer Name: ______________________ Address: ______________________

Occupation: ______________________ email: ______________________

Spouse's Name: ______________________ Spouse's Employer: ______________________

Who may we thank for referring you? ______________________

FOR OUR INSURED PATIENTS

Primary Subscriber Name: ______________________ SS# _____-_____-______ Date of Birth _____/_____/_____

Address: ______________________ City ______________ State _______ Zip ________

Employer: ______________________ Address: ______________________

Insurance Company ______________________ Group #: ______________________

Is there secondary insurance? If so complete the following:

Subscriber's name ______________________ SS# ______________________

Date of Birth: ______________ Insurance Company: ______________________

Group #: ______________________

I authorize release of any information regarding my treatment to my insurance company.

______________________ ______________________

Patient or Subscriber (if present) Date

EMERGENCY CONTACT INFORMATION

Name: ______________________ Relationship ______________________

Home Phone: ______________ Work Phone: ______________________

Reason for today's visit:______________________

Previous Dentist/Date of last visit ______________________

Place a mark on "yes" or "no" to indicate if you currently have had any of the following:

Burning/Numbness sensation on tongue, lip, cheek	❑ Y	❑ N	Loose teeth or broken fillings	❑ Y	❑ N	Chew on one side of mouth	❑ Y	❑ N
Clicking or popping jaw	❑ Y	❑ N	Mouth pain, brushing	❑ Y	❑ N	Grinding teeth	❑ Y	❑ N
Sensitivity to cold	❑ Y	❑ N	Pain around ear	❑ Y	❑ N	Sensitivity to sweets	❑ Y	❑ N
Sensitivity when biting	❑ Y	❑ N	Sensitivity to hot	❑ Y	❑ N	Jaw Pain or tiredness	❑ Y	❑ N
			Swollen/Tender gums	❑ Y	❑ N			