PATIENT REGISTRATION **SUNRISE DENTAL OF OLYMPIA**

Name: _____ **Pref. Name:** _____
(First) (M.I) (Last)

Birth Date: _____ **Soc. Sec. #:** _____ **Driver's Lic:** _____

Address: _____

_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Gender: ( ) Male ( ) Female ( ) Other:_____ **Marital Status: ( ) Married ( ) Single ( ) Minor**

Email: _____

INSURANCE INFORMATION

Are you the policy holder for your dental insurance? ( ) Yes ( ) No --> ***If no please fill out the information below!***

Is this person the Responsible Party for the acct? ( ) Yes ( ) No

Policy Holder: _____ **Relationship to Patient:**_____

Birth Date: _____ **Soc. Sec. #:**_____

Address: _____ **Employer:** _____
(If different from above) _____ _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

How did you hear about our office? _____

Are you or the policy holders for your insurance union members? _____ If so, what union? _____

Dental History

Former Dentist: _____ Last Dental Visit?: _____

City, State: _____ Last Dental Xrays?: _____

Wisdom teeth removed?	( ) Yes ( ) No	Do you Grind or Clench Teeth?	( ) Yes ( ) No
History of Orthodontics?	( ) Yes ( ) No	Habit of Biting Lip or Cheek?	( ) Yes ( ) No
Clicking/Popping of Jaw?	( ) Yes ( ) No	Do you Snore?	( ) Yes ( ) No
Does Your Jaw Lock?	( ) Yes ( ) No	Teeth Sensitive to Hot?	( ) Yes ( ) No
Chronic Dry Mouth?	( ) Yes ( ) No	Teeth Sensitive to Cold?	( ) Yes ( ) No
Habit Fingernail Biting?	( ) Yes ( ) No	Teeth Sensitive to Sweets?	( ) Yes ( ) No
Habit of Ice Chewing?	( ) Yes ( ) No	Get Canker/Cold Sores often?	( ) Yes ( ) No