SimaDental
Family Dental Center

14815 Woodforest Blvd,
Channelview, TX 77530
281-457-6444

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:
____
____
____
____
____