# REGISTRATION for chevy chase dentistry

Name ____________________________________________

Address ______________________________ Zip __________

Phone No. _________________________________________

○adult ○child Birth date of patient (mm/dd/yy) ________________

Name of parent if child is the patient __________________________

Date of Last Visit to Dentist __________

Reason For Call:

○discomfort
○lost filling
○wisdom tooth
○denture problem
○partial problem
○bridge problem
○crown problem
○broken tooth
○implant
○other

how long? ________________________________________

where? __________________________________________

swelling? ________________________________________

bleeding? sensitivity? _________________________________

medication? ______________________________________

○new patient exam ○recare exam

Complaint (state as patient worded it):

Patient Employer ____________________________________

Employer Phone No. __________________________________

Insurance Coverage ○yes ○no ○form available

Social Security No. __________________________________

Additional Information: