SNYDER FAMILY DENTISTRY
REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / / Age:	Sex: ❑ M ❑ F	Street address:	City:	State	Zip-Code

Phone (Home)	Phone (Work)	Phone (Cell) Text: ____Yes ____No	E-Mail

Social Security No.:	Driver's License No.:

Whom may we thank for your referral (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Work

❑ Family ❑ Friend Name of person referring:_____ ❑ Drive-By ❑ Internet ❑ Other

Previous Dentist:	Date of Last Dental Visit:	Reason for leaving:

SPOUSE OR RESPONSIBLE PARTY INFORMATION

(Person responsible for payment on the account if not patient)

Responsible Party Name:	Birth date: / /	Address (if different):	Social Security No. : Driver's License No.:

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance?	❑ Yes	❑ No	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Responsible party signature: X

COSMETIC INFORMATION

Is there anything about your smile that you are not happy with? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight?) _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

If you could change the appearance of your teeth, what would you like to change the most? _____

Is there anything else you would like us to know? _____