



3430 Dodge Street
Inn Plaza
Dubuque, IA 52003
563.556.8388

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____

Patient Is: Policy Holder
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
City: _____ State / Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____
E-mail: _____ I would like to receive correspondences via e-mail.
~~Section 2~~ Section 3 _____
Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hyg.: _____
sent thank you: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ .00 .00 Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ .00 .00 Rem. Deduct: _____

SMILE EVALUATION

Patient's Name _____ Date _____

This is a simple questionnaire to help create the SMILE you have always wanted!

1. Do you like the appearance of your teeth? Yes No
of your smile? Yes No

If not, what would you like to change? _____

2. Are your teeth straight? Yes No

If not, what changes would you make? _____

3. Do you have spaces between your teeth that you are unhappy with? Yes No
Where? _____

4. Do you like the color of your teeth? Yes No

5. Are you happy with the shape of your teeth? Yes No

If not, Why? _____

6. Are your teeth.....

Chipped? _____ Sticking Out? _____ Crowded? _____

7. Do you have any old fillings or crowns that you are unhappy with? Yes No

What would you change? _____

8. What would you like to change about the appearance on your teeth?
