Colliver Dental Group • 2090 Old Farm Drive, Suite B, Frederick, Maryland 21702 • (301) 662-5914

Patient Registration Form

Date: _____

Name: _____ ☐Married ☐Single ☐Minor / ☐Male ☐Female

Soc. Sec. # _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Preferred Phone #: _____

Name of Employer: _____

If full time student, school name: _____ Grade: _____

If the person responsible for this patients account is different from the patient or if the patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Person responsible for account: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Soc. Sec. #: _____ ☐Married ☐Single ☐Minor / ☐Male ☐Female

Email Address: _____ Preferred Phone #: _____

Name of Employer: _____

Insurance Information

Primary Insurance

Policy Holder: _____ Relationship to Patient _____ DOB: _____

Social Security #: _____ Name of Employer: _____

Insurance Company: _____ Insurance ID #: _____ Group #: _____

Insurance Address: _____

Secondary Insurance

Policy Holder: _____ Relationship to Patient _____ DOB: _____

Social Security #: _____ Name of Employer: _____

Insurance Company: _____ Insurance ID #: _____ Group #: _____

Insurance Address: _____

Patient Dental History

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐

	Yes	No
Have you ever experienced any of the following in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty in chewing	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐