Patient Registration
Tammy Mandarino DDS

Patient Information

Patient's Name________________________________ Date________________
Date of Birth______________ If child, parent or guardian's name________________
Address____
City______________________ State______ Zip________________
Phone (home) ____________________ (Cell) ________________________
Phone (work) ____________________E-Mail Address________________
Employer____________________Occupation________________________
In case of emergency call: ____
Whom may we thank for referring you? ____________________________
How do you prefer appointment reminders? (Circle) Home phone Cell phone?

Account Information

Person responsible for payment____
Do you have dental insurance? ___yes___no
Do you have Secondary dental insurance? ____yes____no
Policy holder's name________________________Date of Birth________________
Employer______________________ Employer's Address________________

PRIMARY DENTAL INSURANCE

Insurance Company________________________ Ins. Co. Phone________________
Group #____________________Policy Holder's ID #________________________

SECONDARY DENTAL INSURANCE

Policy holder's name____________________________Date of Birth ______________
Employer______________________Employer's Address________________________
Insurance Company__________________________Ins. Co. Phone________________
Group #______________________Policy Holder's ID #________________________

Dental History

Purpose of this appt.________________________________
Approximately when was your last dental visit? ________________
Approximately when was the last time you had dental x-rays taken? ________
How often do you brush your teeth? ________________________
How often do you floss your teeth? ________________________
Do you use tobacco products? ___________For how long? ____________
Is your water fluoridated? ______________________________
History of Jaw Joint Pain? ______________________________
History of Clenching or grinding your teeth? ________________

Over, please