

**GREG A. LINNEY, DDS., INC.**  
**4660 Sweetwater Blvd., #230**  
**Sugar Land, Texas 77479**

Today's Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

**PATIENT REGISTRATION**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Patient is: Policy Holder \_\_\_\_\_ Responsible Party \_\_\_\_\_

**Patient Information:**

Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Full Time Student: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Security: \_\_\_\_\_

Responsible Party (if someone other than the patient):

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Soc. Security: \_\_\_\_\_ Email: \_\_\_\_\_  
Responsible Party is also a Policy Holder for Patient \_\_\_\_\_ Primary Insurance Policy Holder \_\_\_\_\_

**Primary Insurance Information:**

Name of Insured: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_  
Insured Social Security: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Group or Policy Number: \_\_\_\_\_

Are you having pain or discomfort at this time? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If YES, please describe \_\_\_\_\_

Do you feel nervous about having dental treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Have you noticed any discoloration or stains on your teeth that concern you? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there anything else that concerns you about the appearance of your teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If YES, please describe \_\_\_\_\_

The preceding answers are true and correct. If a change in my health or medication occurs, I will inform the dentist or hygienist at the next appointment without fail.

Signature: \_\_\_\_\_  
(Patient, parent or guardian)