

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

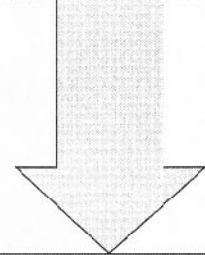
DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELAT ONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Patient Name _____
Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No
- Have you noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores, blisters or any other oral lesions? Yes No
- Do your gums bleed or hurt? Yes No
- Have your parents experienced gum disease or tooth loss? Yes No
- Have you noticed any loose teeth or change in your bite? Yes No
- Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Snore or have any other sleeping disorders? Yes No
- Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
- Oral Surgery? Yes No
- Periodontal treatment? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neckaches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

