Patient Registration Form

Email: Today's Date:

Preferred Name: Miss Mr. Mrs. Dr. Referred By:

Name: Last First M. Home Phone ( ) Cell Phone ( )

Address: City: St.: Zip:

SS#: Birth Date: Sex: M F

Business Phone: include area code

Employer: Full time Part time Retired ( )

Emergency Contact: Relationship : Home: ( ) Cell:( )

Marital Status: Married Single Divorce Separated Widowed

College Student Status: Full time Part time School Name:

Preferred Pharmacy: Phone: ( )

Dental Insurance Information

Primary Insurance:

Name of insured: Relationship to Pt: Self Spouse Child other

Insured Soc. Sec # or ID: Insured Birth Date: Employer:

Employer Address: City: St.:

Secondary Insurance:

Name of Insured: Relationship to Pt: Self Spouse Child other

Insured Soc Sec or ID #: Insured Birth Date:

Employer Address: City: St.:

Dental information for the following questions circle your response

Does your gums bleed when you brush or floss?..... Yes No Don't Know

Are your teeth sensitive to hot, cold, sweets or pressure?.....Yes No Don't Know Is your mouth Dry?....Y N DK

Have you had any periodontal (gum) treatments?.....Yes No Don't Know

Have you had any orthodontic (braces) treatments?.....Yes No Don't Know

Have you had any problems associated with previous dental treatment?.....Yes No Don't Know

Is your home water Fluoridated?.....Yes No Don't Know Do drink bottled water or filtered water?...Yes No

If YES, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

Are you experiencing dental pain or discomfort?.....Yes No Don't Know

Do you have earaches or neck pains?.....Yes No Don't Know

Do you have any clicking, popping or discomfort in the jaw?.....Yes No Don't Know

Do you have brux or grind your teeth?.....Yes No Don't Know

Do you have ulcers in your mouth?.....Yes No Don't Know

Do you wear dentures or partials?.....Yes No Don't Know

Do you participate in active recreational activities?.....Yes No Don't Know

Have you had a serious injury to your mouth or head?...Yes No Don't Know

If yes explain

Date of last exam:_____ What was done at that exam:_____Date of last dental rays:_____

What is the reason for your dental visit today?_____

How do you feel about your smile?_____