PATIENT REGISTRATION Date: _____ Social Security #_____

Name: _____ Birthdate: _____
Last First Middle

Address: _____
Mailing address City State Zip

Home Phone: _____ Business/Cell Phone: _____
Include Area Code

Check appropriate box: Minor___ Single ____ Married ____ Divorced ____ Widowed ___ Separated____

Patient or Responsible Party's Employer: _____ Work Phone _____

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

Spouse:_____ Emergency contact:_____ Phone:_____

DENTAL INSURANCE INFORMATION

Full name of insured_____ Relationship to patient_____

Birthdate_____ S.S. Number_____ Employer_____

Please present insurance card to be copied

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush or floss?	___	___
Are your teeth sensitive to cold, hot, sweets or pressure?	___	___
Does food or floss catch between your teeth?	___	___
Is your mouth dry?	___	___
Have you had any periodontal (gum) treatments?	___	___
Have you ever had orthodontic (braces) treatment?	___	___
Have you had any problems associated with previous dental treatment?	___	___
Is your home water supply fluoridated?	___	___
Are you currently experiencing dental pain or discomfort?	___	___
Do you have earaches or neck pain?	___	___
Do you have any clicking, popping, or discomfort in the jaw joint?	___	___
Do you clench or grind your teeth?	___	___
Do you get frequent sores or ulcers in your mouth?	___	___
Do you get fever blisters on your lip?	___	___
Do you wear dentures or partials?	___	___
Have you ever had a serious injury to your head or mouth?	___	___

What is the reason for your visit today? _____
How do you feel about your teeth?_____
How long has it been since you have been to a dentist?_____

Please continue to second page.....