



WELCOME

Patient Registration and Dental History

Patient Information

Patient Name _____	Date of Birth _____
Social Security # _____	Marital Status _____
Patient Address _____	City, State, Zip _____
Home Phone _____	Work Phone _____
Email address _____	Cell Phone _____
What is the best way to confirm your dental appointments? _____	
Patient's employer _____	Present position _____
Spouse's employer _____	Present position _____
Will the fees for our services be offset by dental insurance? Yes / No _____	
Subscriber Name _____	Relationship to patient _____
Name of Dental Insurance Company _____	
Identification Number _____	Group Number _____
Who may we thank for referring you to our office? _____	

Dental History

What are your current dental concerns? _____

How long has it been since you have been to a dentist? _____

What was done then? _____

How often did you visit a dentist before then? _____

Previous Dentist's name _____ Address _____

Have you had any problems or complications with previous dental treatment? _____

Have you ever had any of the following dental procedures done? If so, please explain.

Gum Treatments or Periodontal Surgery? Yes/No _____

Orthodontic Treatment Yes/No _____

Oral Surgery Yes/No _____

Endodontic Treatment Yes/No _____

Have you ever whitened your teeth? Yes/No Are you interested in whitening? _____

Have you lost any teeth or have any teeth been removed? Yes/No Why? _____

Do you or have you ever experienced any of the following

_____ Hot/Cold Sensitivity	_____ Clench or grind your teeth
_____ Unpleasant Breath	_____ Difficulty opening or closing
_____ Bleeding Gums	_____ Jaw clicks, pops, or locks
_____ Tender Gums	_____ Pain or soreness in your face or by your ear
_____ Food gets caught	_____ Build up a lot of plaque/calculus
_____ Frequently get cavities	_____ Other _____

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

What other products/rinses do you use? _____

Do you usually have teeth numbed for dental work? Yes/No _____

If you could change anything about your teeth or smile what would that be? _____

Are you planning to keep your remaining teeth your whole lifetime? Yes/No _____

Is there anything we can do to make your dental appointment more comfortable? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date: _____

Dentist's Signature _____ Date: _____

Please Complete Other Side