PATIENT REGISTRATION

Work Phone _____

Patient _____ Home Phone _____
LAST NAME FIRST NAME MIDDLE

Birthdate _____ Soc. Sec. No. _____ Driver's License _____ ❑ Male ❑ Female ❑ Single ❑ Married

Address _____ City _____ Zip _____

Employer _____ Occupation _____

Spouse Name _____ Employer _____ Occupation _____

Person Responsible For Account _____ Soc. Sec. No. _____

Address _____ Work Phone _____

Employed By _____ Home Phone _____

In Case of Emergency Call _____ Day Phone _____

Who May We Thank For Referring You To Our Office _____

DENTAL INSURANCE

Ins. Company: _____
Insured Name: _____ D.O.B. _____
Group No. _____ S.S. No. _____
Local _____ Phone _____
Yearly Max _____ Percentage _____

ADDITIONAL DENTAL INSURANCE

Ins. Company: _____
Insured Name: _____ D.O.B. _____
Group No. _____ S.S. No. _____
Local _____ Phone _____
Yearly Max _____ Percentage _____

NG ____ TMJ/BRUX; SEALANT/AGE LIMIT _____ ORTHO _____ PROS. REPLACEMENT _____ COB _____ MTC _____

DENTAL HISTORY

1. What is the reason for your visit?

_____

2. In your estimation, what is the condition ofyour teeth?
   ❑ Good ❑ Fair ❑ Poor
3. Are you satisfied with your teeth and gums? YES NO
4. Are you worried about receiving any aspect of dental treatment? YES NO
5. Are you concerned or do you have any questions about the appearance of your teeth? YES NO
6. Are you presently in any dental pain? YES NO
7. Are your teeth sensitive to hot, cold, sweets, or biting? YES NO
8. Have you ever had any serious complication involving dental treatment? YES NO
9. Specifically, have you ever had any complications with extractions or other dental operations (excessive bleeding, infection, swelling or slow healing? YES NO
10. Have you neglected regular visits in the past? YES NO
11. Have you had any injuries to your teeth, jaws, or face? YES NO
12. Do you have difficulty with your teeth getting numb after an injection of "Novocaine"? YES NO
13. Have you had any of the following dental treatments?
    ❑ Orthodontic treatment (braces)
    ❑ Root canal treatment
    ❑ Partial dentures
    ❑ Wisdom teeth extracted
    ❑ Periodontal treatment (gum surgery)
    ❑ Crown and bridge treatment
    ❑ Dentures
14. Do you have problems with: (please check)
    ❑ Frequent blisters or sores
    ❑ Stained teeth
    ❑ Chewing or eating
    ❑ Bleeding gums
    ❑ Recession of gums
    ❑ Burning of tongue, lips, mouth
    ❑ Shredding floss
    ❑ Cavities (decayed teeth)
    ❑ Toothaches
    ❑ Food wedged between teeth
    ❑ Loose teeth
    ❑ Sinus pressure that causes your teeth to ache
    ❑ Bad taste or mouth odor
15. Do you think you have gum problems (pyorrhea)? YES NO
16. Are you aware of grinding or clenching your teeth day or nights? YES NO
17. Do you have clicking, popping or pain around your ears when you open and close your mouth YES NO

Last Dental Appointment: _____ /Every _____ mos./Dentist _____ City _____