Patient Registration Form

Patient's Name (Last, First, Middle): _____
Preferred Name:_____ Phone #:_____
Email Address:_____
Address:_____Apt. #_____
City:_____State:_____ Zip:_____
Social Security#:_____ Referred By:_____
Marital Status (Circle one): **Married** **Single** **Divorced** **Widowed**
Patient Employer:_____
Emergency Contact:_____ Relationship to Patient:_____
Address:_____Phone #:_____

Dental Information:

Do your gums bleed when you brush or floss? Yes or No
Are your teeth sensitive to cold, hot, sweets, or pressure? Yes or No
Is your mouth dry? Yes or No
Have you had periodontal (gum) treatments? Yes or No
If yes, When?_____ Office:_____
Have you ever had orthodontic (braces) treatment? Yes or No
Have you had problems with previous dental treatment? Yes or No
Is your home water supply fluoridated? Yes or No
Do you drink bottled water or filtered? Yes or No
If yes, how often? (Circle one): **Daily** / **Weekly** / **Occasionally**
Are you currently experiencing any dental pain or discomfort? Yes or No
If yes, where?_____
Do you have any earaches or neck pains? Yes or No
Do you have any clicking, popping, or discomfort in the jaw? Yes or No
Do you grind your teeth? Yes or No
Do you have sores or ulcers in your mouth? Yes or No
Do you brux or grind your teeth? Yes or No
Do you wear dentures or partials? Yes or No
Do you participate in recreational activities? Yes or No
Have you had a serious injury to your head or mouth? Yes or No
Date of your last dental exam?_____ Date of last x-rays?_____
What is the reason for your dental visit today?_____
How do you feel about your smile?_____