PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name:

Patient Information:

Address:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Emergency Contact Name and Phone:

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: Social Security #:

E-mail: □ I would like to receive email correspondences

How did you hear about our office? :

Primary Insurance Information:

Name of Insured: Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Dental History:

Reason for today's visit:

Former Dentist: Last date of dental visit and X-rays:

Circle Yes or No if you have HAD any of the following:

Bad Breath: Y□N□ Gums swollen or tender: Y□N□ Sensitivity when biting: Y□N□

Bleeding Gums: Y□N□ Jaw pain or tiredness: Y□N□ Sores or growths in mouth: Y□N□

Blisters on lips or mouth: Y□N□ Lip or cheek biting: Y□N□

Burning sensation on tongue: Y□N□ Loose teeth/broken fillings: Y□N□

Chew on one side of mouth: Y□N□ Mouth breathing: Y□N□ How often do you floss?

Clicking or popping jaw: Y□N□ Mouth pain,brushing: Y□N□

Dry mouth: Y□N□ Orthodontic treatment: Y□N□ How often do you brush?

Fingernail biting: Y□N□ Ear pain: Y□N□

Food collection between teeth: Y□N□ Periodontal treatment: Y□N□

Foreign objects: Y□N□ Sensitivity to cold/heat: Y□N□

Grinding teeth: Y□N□ Sensitivity to sweets: Y□N□