Patient Registration

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, do not hesitate to ask.

Patient Name _____ Preferred Name _____DOB:_____Sex:_____ Age:_____

Mailing Address _____ City _____State _____ Zip _____

Physical Address (if different than Mailing): _____ City _____State_____Zip_____

Home Phone:_____ Cell:_____ Email:_____ Driver's License#_____

SSN:_____ Employer/Occupation :_____ Bus. Phone_____

Spouse's Name/Phone#_____ Spouse's Employer/Phone# _____

Emergency Phone# (if other than spouse)_____

Primary Dental Insurance _____ Group #_____ ID#_____

Secondary Dental Insurance_____ Group #_____ ID#_____

Primary Medical Insurance_____ Group #_____ ID#_____

Subsciber's Name_____ Date of Birth_____ SSN#_____

Name of Your Medical Doctor_____ Date of Last Visit to Medical Doctor_____

Name of Previous Dentist_____ Date of Last Visit to Dentist_____

Referred to Us By:_____

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment?_____	❑	❑
Have you had problems with previous dental treatment?_	❑	❑
Do you gag easily?_____	❑	❑
Do you wear dentures?_____	❑	❑
Does food catch between your teeth?_____	❑	❑
Do you have difficulty in chewing your food?_____	❑	❑
Do you chew on only one side of your mouth?_____	❑	❑
Do you avoid brushing any part of your mouth because of pain?_____	❑	❑
Do your gums bleed easily?_____	❑	❑
Do your gums bleed when you floss?_____	❑	❑
Have you ever noticed slow-healing sores in or about your mouth?_____	❑	❑
Are your teeth sensitive?_____	❑	❑
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	❑	❑
Cold foods or liquids? _____	❑	❑
Sours?_____	❑	❑
Sweets?_____	❑	❑
Do you take fluoride supplements? _____	❑	❑
Are you dissatisfied with the appearance of your teeth?__	❑	❑
Do you prefer to save your teeth?_____	❑	❑
Do you want complete dental care?_____	❑	❑
Have you had braces, or are you currently in braces?_____	❑	❑
If YES, please provide approx date:_____		
If YES, please provide Orthodontist's name:_____		

	YES	NO
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bother you or others?	❑	❑
Do you clench or grind your jaws frequently?_____	❑	❑
Do your jaws ever feel tired?_____	❑	❑
Does your jaw get stuck so that you can't open freely?____	❑	❑
Does it hurt when you chew or open wide to take a bite?__	❑	❑
Do you have earaches or pain in front of the ears?_____	❑	❑
Do you have any jaw symptoms or headaches upon awaking in the morning?_____	❑	❑
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?_____	❑	❑
Do you find jaw pain or discomfort extremely frustrating or depressing?_____	❑	❑
Do you take medications or pills for pain or discomfort (painrelievers, muscles relaxants, antidepressants)?	❑	❑
Do you have a temporomandibular (jaw) disorder (TMD)?__	❑	❑
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?_____	❑	❑
Are you unable to open your mouth as far as you want?___	❑	❑
Are you aware of an uncomfortable bite?_____	❑	❑
Have you had a blow to the jaw (trauma)?_____	❑	❑
Are you a habitual gum chewer or pipe smoker? _____	❑	❑