WELCOME

DENTAL REGISTRATION & HISTORY

1 PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex: ☐ M ☐ F

Birthdate _____

Patient SS# _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse/Guardian _____

Birthdate _____

Spouse/Guardian SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Driver's License # _____

Insurance Co. _____

Please provide copy of insurance card.

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

3 PHONE NUMBERS

Home (_____) _____

Work (_____) _____ Ext _____

Cell Phone (_____) _____

Spouse's Work (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last full mouth X-rays/Panorex _____

Date of last Bitewing X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Burning sensation or soreness on tongue	☐ Yes	☐ No
Bite lips or cheeks frequently	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Difficult extractions	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food packing between teeth	☐ Yes	☐ No
Grinding or clenching of teeth	☐ Yes	☐ No
Head, neck, or jaw injury	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Clicking	☐ Yes	☐ No
Pain (joint, ear, or side of face)	☐ Yes	☐ No
Difficulty opening or closing mouth	☐ Yes	☐ No
Difficulty chewing	☐ Yes	☐ No
Mobility of teeth	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No

If yes, date of treatment _____

Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sores on lips or mouth	☐ Yes	☐ No
Swollen or tender gums	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

If yes, date of placement _____

Do you like your smile?

If no, what would you change if you could?

_____

Would you like whiter teeth? ☐ Yes ☐ No

– OVER –