Prudential Dental Associates, Inc.
Patient Registration & Dental History

Please take a few minutes to fill out this form as completely as possible. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Today's Date: _____

Name _____ Social Security _____-_____-_____
Last First Middle Initial

Home phone (_____)_____ Work phone (_____)_____ Cell phone (_____)_____

Address _____ E-mail _____

City _____ State _____ Zip code _____ Sex ☐ Male ☐ Female

Age _____ Date of Birth _____ Marital Status ☐ Single ☐ Married ☐ Child

Patient Employer/School _____ Occupation _____

Employer Address _____ Employer phone (_____)_____

Emergency contact (name & phone number) _____

Whom may we thank for referring you? _____

Dental Insurance

Do you have dental insurance? ☐ Yes ☐ No (To be completed by parent or guardian if patient is a minor)

Person responsible for payment _____
Last First Middle Initial

Relation to patient _____ Date of Birth _____ Social Security _____-_____-_____

Address (if different from patients)_____ Phone _____

City _____ State _____ Zip code _____

Responsible party Employer _____ Occupation _____

Employer Address _____ Employer Telephone _____

Insurance Company_____

Contract/Group # _____ Subscriber # _____

Name of all dependents covered by this plan_____

Is patient covered by additional insurance? ☐ Yes ☐ No If yes, please list secondary provider _____

Dental History

Reason for visit _____ Former Dentist _____ City/State _____

Date of last dental visit _____Date of last dental x-rays _____

Check √ to indicate if you have any of the following:

Bad breath	☐	Food collection in teeth	☐	Loose teeth	☐	Sores in mouth	☐
Bleeding Gums	☐	Foreign objects	☐	Mouth breathing	☐	Sensitivity to cold	☐
Broken fillings	☐	Grinding teeth	☐	Mouth pain	☐	Sensitivity to heat	☐
Clicking/popping jaw	☐	Gums swollen /tender	☐	Orthodontic treatment	☐	Sensitivity to sweets	☐
Dry mouth	☐	Jaw pain or tiredness	☐	Pain around ear	☐	Sensitivity when biting	☐
Fingernail biting	☐	Lip or cheek biting	☐	Periodontal treatment	☐		

Please complete both sides