PATIENT REGISTRATION

First Name: _____ MI:_____ Last: _____Nickname:_____
Home Phone:_____ Work Phone: _____ Cell: _____
Date of Birth: _____ ☐ Male ☐ Female SS#:_____
Address: _____ City: _____
State: _____ Zip: _____
Employer: _____
State/Driver's License #: _____ Email: _____
Name of Primary Physician: _____ Phone: _____
Emergency Contact: _____ Relationship: _____Phone: _____
Dental Insurance: _____ Insurance Phone: _____
ID#: _____ Group Policy #: _____
Policy Holder Name:_____ Policy Holder Date of Birth: _____

DENTAL HISTORY INFORMATION

Date of Last Dental Visit: _____ X-rays taken? ☐ Yes ☐ No
Name of Previous Dentist: _____ Do you have problems with bad breath? ☐ Yes ☐ No
Previous Dentist Phone#: _____ Are you sensitive to hot/cold/pressure? ☐ Yes ☐ No
How often do you floss your teeth? _____ How often do you brush your teeth? _____
Do your gums bleed when you brush? ☐ Yes ☐ No Have you ever used an electric toothbrush? ☐ Yes ☐ No
Have you or a family member ever been treated for periodontal disease? ☐ Yes ☐ No
Have you ever had any complications from an extraction? ☐ Yes ☐ No Please explain: _____
Have you ever had any popping or clicking near your ear when you chew? ☐ Yes ☐ No
Are you prone to frequent headaches? ☐ Yes ☐ No Do you grind your teeth? ☐ Yes ☐ No
Do you have any sores, blisters or swelling on your gums, lips or cheeks? ☐ Yes ☐ No
Have you ever had any orthodontic treatment? ☐ Yes ☐ No On a scale of 1 to 10, with 10 being the highest, how important is your dental health to you? _____

If you could change something about your smile what would it be?

- ☐ Whiter
- ☐ Straighter
- ☐ Close Space
- ☐ Replace dark/metal (amalgam) fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be necessary by the Doctor.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____