Patient Registration Form

Email:			Today's Date:
Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.		How did you find out about us:	
Name: Last First Middle		Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
Address: Mailing address		City:	State: Zip:
SS#:		Date of Birth:	Sex: M F
Employer:		Business Phone: *include area code* ( )	
Emergency Contact:	Relationship:	Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time	Please provide school info:	School Name:_____	
Employment Status: ❑ Full Time ❑ Part Time ❑ Retired		Address:_____	
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		Address 2:_____	
Pref. Pharmacy: Phone: ( )		City, State, Zip:_____	

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____	Ins. Company: _____
Address of Policy Holder: _____	Address: _____
Address Line 2: _____	City, State, Zip:_____
City, State, Zip:_____	Ins. Company Phone #:_____

Insurance ID#: _____ **Group ID#:** _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____	Ins. Company: _____
Address of Policy Holder: _____	Address: _____
Address Line 2: _____	City, State, Zip:_____
City, State, Zip:_____	Ins. Company Phone #:_____

Insurance ID#: _____ **Group ID#:** _____

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

Anxiety seeing the dentist: NONE / MILD / MODERATE / SEVERE

What is the reason for your dental visit today?

How do you feel about your smile?