Jeffrey R. Wert, D.M.D., P.C.

Patient Registration Form

Date: ____________
Patient Name: ________________________________ Birthdate: __________________ Sex: M F
Address: ____
Email Address: ___________________________________ Home Phone: _____________________
SSN:______-_____-_________ Marital Status: **S M D W** Cell Phone: ________________________

Employer: __________________________________ Work Phone: _________________ Ext:______
If student, School: ____________________________________ Grade:_______________________

Spouse/Parent Name: ____
Spouse/Parent Employer: _____________________________ Phone:________________ Ext:______
Emergency Contact:_________________________________ Phone: _________________________

Person Responsible For Account

Name: ____________________________________ Relationship to Patient: __________________
Address: ____ Phone: _________________________
Employer: __________________________________ ID/SSN: ______________________________
Insurance Company: _____________________________ Group No: _________________________

Secondary Ins Co: ________________________ Policy Holder: _____________________________
Relationship to Pt: ______________ ID No.:_________________ Group No: ____________________
Employer: ____

Dental History

Date of last dental visit: _________________________ Reason for visit: _______________________
Date of last cleaning: ____________________________ Date of last x-rays: ____________________
Previous Dentist: ______________________________ Reason for leaving: _____________________

Have you had any of the following?

Loose Teeth	Yes No
Gum Pain/swelling	Yes No
Bleeding when brushing	Yes No
Gum/periodontal disease	Yes No
Periodontal Surgery	Yes No
Oral Surgery	Yes No
Root Canal Treatment	Yes No
Orthodontics	Yes No
Click/noise in jaw	Yes No
Pain in ear or jaw	Yes No
Pain or difficulty chewing	Yes No
Pain opening mouth	Yes No
Treatment for TMJ	Yes No
If child, suck thumb/finger?	Yes No

Injury to head or mouth? Yes No
Describe: ____________________
History of Headaches? Yes No
How frequently? ______________

Sensitivity? Cold Hot Sweet
Do you have any of the following habits?

Grind or clench teeth?	Yes No
Bite nails?	Yes No
Hold objects in mouth?	Yes No
Breathe through mouth?	Yes No
Smoke or chew tobacco?	Yes No
Drink coffee or tea?	Yes No

How often do you brush? ________ Type of toothbrush? _______ If child, does a parent help? ______
Do you floss? _______ If so, how frequently? _______ Fluoride taken in any form? ________________
How do you feel about having dental treatment done? Have you ever had an uncomfortable experience? ____
Is there anything else we should be aware of? ____

Signature: ____