

Date \_\_\_\_\_

# Patient Registration Form

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F

Address \_\_\_\_\_ Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Marital Status: S M D W

Employer \_\_\_\_\_ Work Ph. \_\_\_\_\_ Ext. \_\_\_\_\_

If student, School attending \_\_\_\_\_ Grade \_\_\_\_\_

Spouse/Parent name \_\_\_\_\_

Spouse/Parent Employer \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## Person Responsible for account

Name \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ ID/Soc. Sec. No. \_\_\_\_\_

Ins. Company \_\_\_\_\_ Group No. \_\_\_\_\_

Secondary Ins. \_\_\_\_\_ 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 or difficulty opening mouth	Yes	No
Treatment for TMJ	Yes	No

Injury to head or mouth	Yes	No	
Describe _____			
History of headaches	Yes	No	
How frequently _____			
Sensitivity?	Cold	Hot	Sweet

Do you have the following habits?:

Grind or clench teeth	Yes	No
Bite nails	Yes	No
Hold objects in mouth	Yes	No
Mouth breathe awake or asleep	Yes	No
Smoke or chew tobacco	Yes	No
Drink coffee or tea	Yes	No

If child: Pacifier or Thumb/Finger sucking? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Type of toothbrush \_\_\_\_\_ If child, does a parent help? \_\_\_\_\_

Do you floss? \_\_\_\_\_ How frequently? \_\_\_\_\_ Fluoride taken in any form? \_\_\_\_\_

How do you feel about having dental treatment done? Have you ever had an uncomfortable experience?

Explain \_\_\_\_\_

Is there anything else we should be aware of? \_\_\_\_\_

Signature \_\_\_\_\_