WELCOME

Personal Information

Date: _____

Patient's Name: _____ Date of Birth: _____ Male Female
Last First Middle Circle One

If Child, Parent's Name: _____

Address: _____ City: _____ State:_____ Zip:_____

Telephone: Home _____ Cell _____ Work _____

Social Security Number: _____ Email:_____

Spouse Name: _____ Spouse Date of Birth: _____

Whom may we thank for this referral: _____

Insurance Information

If you have secondary coverage, complete the following:

Employee: _____ Date of Birth _____ *Employee:* _____ *Date of Birth* _____

Social Security Number of Employee _____ *Social Security Number of Employee* _____

Name of Insurance Co. _____ *Name of Insurance Co.* _____

Policy Number _____ *Policy Number* _____

Dental Information

What brought you in today? _____

How long since your last dental visit? _____

When was the last time your teeth were cleaned? _____

Do you have fears/anxiety about dental work? _____

Previous dentist's name _____

Are any of your teeth sensitive to (circle all that apply): Hot Cold Sweets Pressure

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever had gum treatment or surgery? _____ If yes, how long ago? _____

Have you ever had a root canal treatment? _____ If yes, how long ago? _____

Have you ever had braces to straighten your teeth? _____ If yes, how long ago? _____

Have you ever had difficulty opening, closing, or chewing? _____

How do you feel about your teeth in general? _____

Patient / Parent Signature: _____ Date: _____

REGISTRATION / DENTAL HISTORY