REGISTRATION	
MR. MRS. MISS	DATE OF BIRTH S M W D
HOW WOULD YOU LIKE TO BE ADDRESSED	HOME PHONE
HOME ADDRESS	
MAILING ADDRESS	
EMAIL ADDRESS	CELL PHONE
EMPLOYER	WORK PHONE
CITY/STATE	OCCUPATION
PREFERRED DAY FOR APPTS	TIME
PERSON RESPONSIBLE FOR ACCOUNT	
ADDRESS	

INSURANCE INFORMATION	
NAME OF INSURED	RELATIONSHIP TO PATIENT
DATE OF BIRTH	SS# / ID#
NAME OF EMPLOYER	GROUP #
DENTAL INSURANCE COMPANY	
ADDRESS	PHONE #
ADDITIONAL COMMENTS	

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Are your teeth sensitive to - Heat? Cold? Sweets? Biting Pressure?

Do your gums bleed while brushing? . . . . YES NO

Have you noticed any gum swelling around any teeth? . . . . YES NO

Do you ever avoid any part of the mouth while brushing? . . . . YES NO

Are you dissatisfied with your teeth and their appearance? . . . . YES NO

Are you deeply concerned about the finances required to return your mouth to excellent dental health? . . . . YES NO

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? . . . . YES NO

Do you want to learn to control dental disease and retain your teeth? . . . . YES NO

Do you have an unpleasant taste or odor in your mouth? . . . . YES NO

Do you smoke? . . . . YES NO

Have you ever had any teeth removed? . . . . YES NO

How long have these teeth been missing? ____________________

Do you feel you will eventually wear artificial dentures? . . . . YES NO

Do you have any dental fears? . . . . YES NO

If so, explain ____________________

Do you clench or grind your teeth? . . . . YES NO

Have you ever had orthodontic treatment? . . . . YES NO

Referred By: ____________________