

**PATIENT REGISTRATION**

Patient's Name \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_\_ Today's Date \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Please Circle One: Single Married Divorced Widowed Home Phone Number \_\_\_\_\_  
Employer \_\_\_\_\_ How Long \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email: \_\_\_\_\_ Can we contact you via email? Yes/No  
Spouse's Name (Parent if Minor) \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Birtdate \_\_\_\_\_ Spouse's SS# \_\_\_\_\_  
Referred to us by \_\_\_\_\_ Reason for visit \_\_\_\_\_  
Emergency Contact – Name, Address & Telephone Number of a relative not living with you  
\_\_\_\_\_

**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_ Insurance  
Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Group# \_\_\_\_\_

**DENTAL HISTORY**

How long since you have seen a dentist? \_\_\_\_\_  
Last complete dental exam date: \_\_\_\_\_  
Last full mouth x- ray date: \_\_\_\_\_  
Are you having problems now? Y N What? \_\_\_\_\_  
Is your present dental health poor? Y N  
Do you wear dentures? (Partials or Full) Y N  
Are you UNHAPPY with your dentures? Y N Why? \_\_\_\_\_  
Have you had BAD dental experiences in the past? Y N  
Are you APPREHENSIVE about dental treatment? Y N  
Have you had PERIODONTAL (gum) treatments? Y N  
Do your gums BLEED or feel TENDER or IRRITATED? Y N  
Are your teeth SENSITIVE to hot, cold, sweets or pressure?(circle) Y N  
Are you UNHAPPY with the APPEARANCE of your teeth? Y N  
Are you aware of GRINDING or CLENCHING your teeth? Y N  
Do you have HEADACHES, EARACHES, or NECK PAIN? Y N  
Do you have LOOSE, TIPPED or SHIFTING teeth? (circle) Y N  
Have you worn BRACES on your teeth? (orthodontics) Y N  
Do you have DISCOLORED teeth that bother you? Y N  
Would you like you smile to LOOK BETTER OR DIFFERENT? Y N  
Do you have problems with teeth/fillings BREAKING? Y N  
Do you REGULARLY use DENTAL FLOSS? Y N  
How do you feel about your teeth? \_\_\_\_\_  
Previous Dentist? \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

Fear of Pain \_\_\_\_\_ Cost of Treatment \_\_\_\_\_ Lack of Concern \_\_\_\_\_ Missing Work Time \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_

The above signed hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate. I also authorize Doctor to perform any and all forms of treatment, medication and therapy. I also understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time service is rendered unless financial arrangements have been made. I also assign all insurance benefits to the doctor. In the event the balance of this account is turned over for collection the above signed will be responsible for collection cost and reasonable attorney's fees.