PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Date___/___/___
Patient's Full Name _____ Age _____ Birthdate ____/____/_____

Address _____

City _____ **State** _____ **Zip** _____

Work Phone Number _____ **Home Phone Number** _____
Cell Phone Number _____ **Email Address** _____
Patient Social Security Number _____

DENTAL INSURANCE
Primary Carrier Insurance Company _____ **Employee** _____

Group No. _____ **Emp. Date of Birth** _____**Emp. Social Security No.** _____

ACCOUNT INFORMATION
Name of Person Financially Responsible for Account _____

Address _____

City _____ **State** _____**Zip**_____

Occupation _____ **Employer** _____

Business Address _____ **City** _____

Business Telephone _____ **Ext.** _____
Marital Status (Check) Married ____ Single ____ Divorced ____ Widowed ____ Separated ____

Spouse Name _____

Spouse's Occupation_____ **Spouse's Employer** _____

Business Address (Spouse) _____ **City** _____

Business Telephone (Spouse) _____ **Ext.** _____

Person To Contact For Emergency _____ **Phone No.** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Referred to Us By _____

DENTAL HEALTH HISTORY

1. **Chief Complaint or reason for visit** _____
2. **Date of last dental visit** _____
3. **Are you experiencing discomfort from your mouth at this time?** _____
   Explain:_____
4. **Have you had full mouth x-rays (18 x-rays) or a panorex within the last two years?** _____
5. **Circle any of the following which you have had or have at present:**

Periodontal (gum) treatment	**Orthodontic (braces) treatment**
Endodontic (root canal) treatment	**Bleeding sore gums**
Swelling or lumps in mouth	**Difficulty opening or closing jaw**
Clenching/grinding	**Loose teeth**
Tooth sensitivity to biting	**Tooth sensitivity to cold**
Tooth sensitivity to hot	**Food impaction**

6. **Are you satisfied with the appearance of your teeth?** _____
7. **Does your drinking water contain fluoride?** _____