

**PATIENT REGISTRATION**

**Patient Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

**Sex:**  Male  Female      **Marital Status:**  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Who May We Thank for Referring You to our Office \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired      Emergency Contact: \_\_\_\_\_

Place of Employment: \_\_\_\_\_      Emergency Phone: \_\_\_\_\_

Student Status:  Full Time  Part Time      Pref. Pharmacy: \_\_\_\_\_

Pref. Hygienist: \_\_\_\_\_

**Responsible Party (If someone other than the patient)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient     Primary Insurance Policy Holder     Secondary Insurance Policy Holder

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

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**"Dental History"**

HOW LONG SINCE you have seen a Dentist? \_\_\_\_\_

Date of Last COMPLETE Dental Exam, Date: \_\_\_\_\_

Date of last FULL MOUTH X-RAYS, Date: \_\_\_\_\_ (18 small films or Panoramic)

**YES NO**

\_\_\_ \_\_\_ Are you having PROBLEMS now? If so, WHAT? \_\_\_\_\_

\_\_\_ \_\_\_ Do you wear (Partials or Full) DENTURES? If so are you UNHAPPY with your dentures? \_\_\_\_\_

\_\_\_ \_\_\_ Would you like to know more about PERMANENT REPLACEMENTS?

\_\_\_ \_\_\_ Are you APPREHENSIVE about dental treatment?

\_\_\_ \_\_\_ Have you had any PERIODONTAL (GUM) treatments?

\_\_\_ \_\_\_ Do your gums BLEED, or feel TENDER or IRRITATED?

\_\_\_ \_\_\_ Are you aware of GRINDING OR CLENCHING YOUR TEETH?

\_\_\_ \_\_\_ Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)

\_\_\_ \_\_\_ Do you have HEADACHES, EARACHES, or NECK PAINS?

\_\_\_ \_\_\_ Have you worn BRACES on your teeth? (ORTHODONTICS)

\_\_\_ \_\_\_ Do you have DISCOLORED teeth that bother you?

\_\_\_ \_\_\_ Would you like your smile to LOOK BETTER or DIFFERENT?

\_\_\_ \_\_\_ Do you REGULARLY use DENTAL FLOSS?

How would you rate your dental health? (circle)      GOOD      FAIR      POOR

How do you feel about your teeth? \_\_\_\_\_

Name of Previous Dentist: \_\_\_\_\_ City, State: \_\_\_\_\_

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment. (#1 being of most concern)

Fear of pain: \_\_\_\_\_ Cost of treatment: \_\_\_\_\_ LACK of concern: \_\_\_\_\_ MISSING work time: \_\_\_\_\_