

PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Date / /
Patient's Full Name _____ Age Birthdate / /
Address _____
City _____ State _____ Zip _____
Work Phone Number _____ Home Phone Number _____

DENTAL INSURANCE

Patient Social Security Number _____
Primary Carrier Insurance Company _____ Employee _____
Group No. _____ Date Employed _____ 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 panorax 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? _____