

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE			
DATE			
NAME			
SPOUSE			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NUMBER			
EMAIL			
DATE OF BIRTH	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NUMBER			
IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE			
DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NUMBER			
DATE OF BIRTH	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NUMBER			
IF YOUR CHILD'S NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO			

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
INSURANCE PLAN NAME	
EMPLOYER	
PRIMARY INSURED	
GROUP PLAN	
GROUP NO.	
DATE OF BIRTH	DATE EMPLOYED
SUBSCRIBER ID NO.	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
INSURANCE PLAN NAME	
EMPLOYER	
PRIMARY INSURED	
GROUP PLAN	
GROUP NO.	
DATE OF BIRTH	DATE EMPLOYED
SUBSCRIBER ID NO.	
EMPLOYEE SOCIAL SECURITY NO.	

ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY	
PHONE NUMBER	
YOU	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NUMBER	
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NUMBER	

GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP
REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE
EMERGENCY CONTACT	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE

APPOINTMENT REMINDERS	
WE EMAIL AND SMS (TEXT) TO REMIND YOU OF YOUR APPOINTMENT	
EMAIL (ALTERNATE, IF DESIRED)	
MOBILE	Check here to opt-out of email/text reminders <input type="checkbox"/>

Patient Name	Dental/Medical History
Patient Account No.	Medical Alert

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____’s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient Signature_____Date_____

Parent or
Responsible Party_____Relationship to Patient_____

Patient Name	Dental History
Patient Account No.	Medical Alert

WELCOME! So that we may provide you with the best possible care please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____
What was done at your last dental visit? _____

Previous Dentist's Name _____
Address _____ State _____ Zip _____
Telephone _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum diseases or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails)?	Yes	No
Mouth breathe while awake or sleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with you teeth's appearance?

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern? _____		

Have you ever had an upsetting dental experience? Yes No
If so, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

(Please complete other side)

