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Welcome to our office. Please provide the following information. It is important to our records and your health.

PATIENT REGISTRATION AND DENTAL HISTORY

Today's Date_____/_____/_____

Please explain your reason for seeking dental treatment so that we may best meet your needs: _____

_____

Who may we thank for referring you to our office? _____

Patient's Name (Mr./Dr./Mrs./Ms.)_____SS#_____Birthdate_____/_____/_____Age _____

Residence Address_____ E-mail_____

City_____State_____Zip_____Home Phone _____Cell Phone_____

Occupation_____Employer_____ Business Phone_____

Business Address_____City_____State_____Zip_____

Preferred Method of Contact_____

Name of Spouse/ Guardian_____SS#_____

Occupation_____Employer_____ Business Phone_____

Business Address_____City_____State_____Zip_____

Responsible Party if Patient is a minor_____ Relationship to minor_____

Address(Home/Business)_____Phone(Home/Business)_____

Name, address, and Phone of a relative **NOT** living with you: _____

_____

Party responsible for Payment of Account: _____

DENTAL HISTORY

Your previous Dentist_____How Long?_____Last dental x-ray date ?_____

When was your last teeth cleaning by a Hygienist?_____ # Cleanings per Year?_____

How often do you brush?_____Floss?_____See your Dentist?_____

DO YOU OR HAVE YOU EVER HAD*: *(Circle)

Yes/No	Head or neck Injuries	Yes/No	Anxiety of dental treatment	Yes/No	Reaction to "Novocain"
Yes/No	Sore or sensitive teeth	Yes/No	Sores on lips/mouth that are slow to heal	Yes/No	Bleeding /slow healing
Yes/No	Bleeding gums	Yes/No	Orthodontic treatment		after an extraction
Yes/No	Grind or clench teeth	Yes/No	Periodontal disease (gum disease)	Yes/No	Dissatisfaction with the
Yes/No	Difficulty chewing	Yes/No	Trouble opening/closing your jaw		appearance of your teeth