Dental Patient Registration

Patient Information

Patient Name: _____ DOB: _____ Gender: _____
Home Phone: _____ Cell: _____
Address: _____ @ _____
Email: _____
Dependent? _____ If yes, Guardian's Name: _____
Guardian's Phone: _____ Cell: _____
Insurance: Yes or No (underline answer) If yes, Insurance Company: _____
Emergency Contact: _____ Relationship: _____

Dental History

Last Dentist Visit: _____ Last X-Rays: _____
Previous Dentist: _____ Reason for Leaving: _____
Previous Medications: _____
Allergies: _____
Previous Periodontal Treatment: _____
Previous Orthodontic Treatment: _____
Sensitivities to Medicines or Anesthetics: _____
History of: ❑ Heart Disease ❑ Diabetes ❑ Stroke ❑ High Blood Pressure ❑ Cancer ❑ Asthma

Dental Issues

Current Pain Level (1 – 10): _____ Happiness with Aesthetics (1 – 10): _____
Current Medications: _____
Description of Dental Issue: _____
Teeth Brushing Frequency: _____ Flossing Frequency: _____
Mouthwash Frequency: Scheduled Cleaning Frequency:

I Have…
(Please Check All That Apply)

- ❑ Pain when chewing
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity to pressure
- ❑ Painful/broken fillings
- ❑ Swollen gums
- ❑ Bleeding gums
- ❑ Dry mouth
- ❑ Bad Breath
- ❑ Jaw clicking/popping
- ❑ Teeth grinding while sleeping
- ❑ Fingernail chewing
- ❑ Sores/growths/lesions in mouth
- ❑ Fear of dental work
- ❑ Fear of needles
- ❑ Other: _____
- ❑ Other:

I verify that the above information is factual and true to the best of my knowledge. I authorize the dentist to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper dental care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

Patient

Date