NEW PATIENT REGISTRATION

Last Name:

First Name

Middle Initial:

Preferred Name:

Gender:
Male
Female

Status:
Married:
Single:
Child:
Other:

Date of Birth:

Optional if using Insurance:
Social Security #:
Employer
Primary Dental Insurance
Subscriber:
Self
Other

Street Address:

City, State, Zip

Contact Phone #:

Email:

Best way to contact you?:

Medical History Questionnaire:

How do you rate your health?

Average
Good
Poor
I don't know

Do you have any existing illness that requires regular medical care? (If yes please explain)
Yes
No

Do you have any drug allergies? (If yes please explain)
Yes
No

Are you taking any prescription medication? (If yes please explain)
Yes
No

Do you take blood thinning medication?
Yes
No

Women
Are you or do you think you might be pregnant?
Yes
No
Are you taking oral contraceptives
Yes
No
Are you nursing?
Yes
No

Dental History Questionnaire

What are you coming in for today?
When was your last dental exam?
When was your last dental cleaning?

Are your teeth sensitive to hot/cold food or liquids?
Yes
No

Are your teeth sensitive to sweet or sour foods?
Yes
No

Do your gums bleed while brushing or flossing?
Yes
No

Are you experiencing any dental pain?(If Yes please explain)
Yes
No

Do you have any unhealed sores or lumps in or near your mouth (If Yes please explain)
Yes
No

Do you clench or grind your teeth? Have you worn a nightguard?
Yes
No

Have you experienced any of the following problems in your jaw? (Circle all that apply)
Clicking
Pain (joint, ear, side of face)
Difficulty in opening closing mouth
Difficulty chewing
Lock jaw

Have you had orthodontic work
Yes
No

Dental History Questionnaire (Continued)

Do you smoke or use any tobacco products? (If Yes please indicate frequency and amount)
Yes
No

Do you drink alcohol? (If Yes please indicate frequency and amount)
Yes
No

Please select any dental concerns that you may have:
Bad Breath
Bleeding gums
Crooked teeth
Chipped teeth
Food traps
Poor fitting crowns/bridges

Do you have any dental concerns that are not listed?

How would you rate your smile?

If you could change anything about your smile what would you change?

Have you ever considered teeth straightening with Invisalign?
If Yes, ask us about our Smile Assessment Form

Thank you for completing this questionnaire!!!