Patient Registration Form

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: O Miss O Mr. O Mrs. O Ms. O Dr. Referred by:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: O Full Time O Part Time Please provide school info:

Employment Status: O Full Time O Part Time O Retired

Marital Status: O Married O Single O Divorced O Separated O Widowed

Pref. Pharmacy: Phone: ( )

School Name:__________

Address:__________

Address 2:__________

City, State, Zip:__________

Dental Insurance Information

Primary Insurance Information

Name of Insured: __________ Relationship to Patient: O Self O Spouse O Child O Other

Insured Soc. Sec.: __________ Insured Birth Date: __________

Employer:__________ Ins. Company: __________

Address:__________ Address: __________

Address 2:__________ Address 2: __________

City, State, Zip:__________ City, State, Zip: __________

ID#: __________ Gr#:__________

Secondary Insurance Information

Name of Insured: __________ Relationship to Patient: O Self O Spouse O Child O Other

Insured Soc. Sec.: __________ Insured Birth Date: __________

Employer:__________ Ins. Company: __________

Address:__________ Address: __________

Address 2:__________ Address 2: __________

City, State, Zip:__________ City, State, Zip: __________

ID#: __________ Gr#:__________

Dental Information

For the following questions, mark (X) your responses to the following questions.

Question	Yes	No	DK
Do your gums bleed when you brush or floss?	O	O	O
Are your teeth sensitive to cold, hot, sweets or pressure?	O	O	O
Is your mouth dry?	O	O	O
Have you had any periodontal (gum) treatments?	O	O	O
Have you ever had orthodontic (braces) treatments?	O	O	O
Have you had any problems associated with previous dental treatment?	O	O	O
Is your home water supply fluoridated?	O	O	O
Do you drink bottled or filtered water?	O	O	O
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	O	O	O

Question	Yes	No	DK
Do you have earaches or neck pains?	O	O	O
Do you have any clicking, popping or discomfort in the jaw?	O	O	O
Do you brux or grind your teeth?	O	O	O
Do you have sores or ulcers in your mouth?	O	O	O
Do you wear dentures or partials?	O	O	O
Do you participate in active recreational activities?	O	O	O
Have you ever had a serious injury to your head or mouth?	O	O	O

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

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