REGISTRATION & DENTAL HISTORY

M____. Name: _____ Date:_____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Email _____

Birthdate:_____ Social Security #: _____ Occupation:_____

Employer:_____ Employer Address:_____

Dental Insurance:_____ Medical Insurance: _____

If Married, Spouse's Name:_____ Birthdate:_____ Social Security # _____

Spouse's Employer:_____ Dental Insurance: _____ Medical Insurance: _____
(If different than above) (If different than above)

Responsible Party's Name on Account: (If different than above) _____ Address:_____

Birthdate: _____ Social Security #:_____ Phone: _____

DENTAL HISTORY (Please answer ALL questions)

1. Why are you seeking care at this time?_____

2. Since your last dental appointment are there any questions/ problems regarding your dental health you would like answered or discussed?_____

3. Are you apprehensive about receiving dental treatment? _____
Why? (fear or vibrations, injection, past experiences, etc) _____

4. How long has it been since your last complete dental examination?_____

5. Have you experienced any discomfort from your teeth lately?_____
If so, where?_____ Describe (pressure, temperature change, sweets, etc.)_____

6. Have you experienced any discomfort from your gums lately? _____
Describe _____ Do they bleed easily? _____

7. Have you noticed any discomfort or any unusual changes in the soft tissues of the mouth? (tongue, cheek, throat, lips, etc.)_____

8. How often do you brush? _____ Do you use dental floss? (frequency) _____
Are you frequently troubled with bad breath?_____

9. Do you have any unusual eating habits?_____
Do you snack between meals frequently?_____

10. Does the appearance of your teeth, in any way, make you self-conscious?_____
Explain:_____

11. Would you like to retain your natural teeth as long as possible? _____ If not, why not? _____

12: Do any of the following apply? (PLEASE CHECK THOSE THAT APPLY)

Popping _____	Snapping noises when you chew _____	Pain when opening wide _____ _	Discolored teeth _____
Clicking _____	Missing teeth other than wisdom teeth _____	Clenching your teeth _____	Frequent headaches _____
Loose teeth _____	Have missing teeth been replaced _____	Shifted or tipped teeth_____	Grinding teeth in sleep _____
Loose fillings _____	Fillings that have to be replaced often _____	Chipped or discolored fillings____	Nerves removed _____

13. Has the condition of your teeth ever been completely explained to you?_____

14. Are you satisfied with your past dentistry? _____

15. Would you prefer a local anesthetic (injection) for most dental treatment? _____

16. Have you ever received sedative or tranquilizing drugs for dental procedures?_____ If so, what form was it given? Injection _____ Inhalation _____
Oral (pill, elixir,etc.)_____. Were you pleased with the results?_____

17. Whom may we thank for this referral?_____

18. Name of previous dentists_____ May we request your previous dental records_____