PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date:

Patient Name ______________________________ Nick Name ____________ Date of Birth ________ Age ___
First Middle Last

Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Domestic Partner ☐ Minor Child

Spouse/Domestic Partner/Parent Name ______________________________ Phone ______________

Sex: ☐ Male ☐ Female SSN # _____-_____-_____ Driver's License # ______________

Address ______________________ City ______________ State _____ Zip ________

E-Mail ______________ Whom may we thank for referring you? ______________

Nearest relative not living with you & relationship ______________________ Phone ______________

Primary Medical Doctor ______________________ Phone ______________

Previous Dentist ______________________ Phone ______________

Current or Former Orthodontist ______________________ Phone ______________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Current Employer ______________________ Bus. Phone ______________

Occupation ______________________

Who will be responsible for this account? ______________________ Relationship to Patient ______________

Billing Address ______________________ Phone ______________

PHONE NUMBERS

Home ( ) ______________ Work ( ) ______________ Cell ( ) ______________

IN CASE OF EMERGENCY, CONTACT ______________________ Phone ( ) ______________
Name Relationship

DENTAL HISTORY

Reason for today's visit? ______________________ Date of last dental visit? ______________

Date of last dental x-rays? ________ How often do you brush your teeth? ________ Floss your teeth? ________

Circle below if you have had any of the following:

Bad Breath	Bleeding gums	Blisters on lips/mouth	Burning sensation on tongue or lips
Chew on one side of mouth	Clicking or Popping jaw	Dry mouth	Grinding or clenching teeth
Gums swollen or tender	Loose teeth or broken fillings	Tooth sensitivity to cold	Tooth sensitivity to hot
Tooth sensitivity to sweets	Tooth sensitivity when biting	Jaw pain or tenderness	Mouth pain when brushing
Food collection between teeth	Mouth breather	Pain around ear	Sores/growths in mouth
Smoker (cigarette/cigar/pipe)	Chew tobacco	Yellow or discolored teeth	Orthodontic treatment
Periodontal treatment	Lip or cheek biting	Removable dental appliance	Difficulty opening/closing jaw
Recent infections or sore throat	Gum disease	Other? ______________	

I acknowledge that the above information is accurate to the best of my knowledge.

X Signature of Patient (Parent or Guardian if a Minor) ______________________ **Date** ______________