Registration and Dental History

It is important that we know about your dental history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission. ***IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE OF ANY CHANGES TO YOUR DENTAL INSURANCE INFORMATION—BENEFIT COVERAGE—WAITING PERIODS—PLAN EXCLUSIONS—ETC!***

PATIENT'S INFORMATION:

Patient's Name _____

Single _____Married_____Divorced_____Separated_____Widowed____

Birthdate _____Home Phone _____

Cell Phone _____Work Phone _____

Preferred Contact Number: Home_____ Work _____ Cell _____

Address _____

City _____ State _____ Zip _____

E-Mail Address _____

Employed by _____ FT Student yes / no

Name of Relative not living with you _____

Relationship _____

Address _____ Phone_____

Referred by _____Flyer ___ Web ___ Phone Bk__

Who will pay for this account? _____

INSURANCE INFORMATION:

Name of Subscriber _____Birthdate_____

Employed by _____

Name of Dental Ins Co. _____

Phone Number of Ins. Co. _____

Insurance ID # / SS# _____

Group # _____ Policy #_____

Spouse's/Guardian's or **Parent's INFO if patient is a child/minor**

Name _____ Birthdate_____

Employed by _____

2ndary Insurance Co.(if applicable) _____

Insurance ID # / SS#_____

Policy# _____ Group # _____

Phone Number of 2ndary Ins. Co. _____

Please check all that apply.

_____ Discomfort at this time _____ Heat sensitivity

_____ Cold sensitivity _____ Biting sensitivity

_____ Sweet sensitivity _____ Grind or clench teeth

_____ Popping or clicking in jaw _____Use water jet

_____ Pain in or around ears _____Teeth straightened

_____ Use dental floss. How Often _____

_____ Food wedges between teeth--Where _____

_____ Eat between meals _____ Brush after snacks

_____ Complications with extractions

_____ Bad breath _____ Bleeding gums

_____ Unpleasant taste in mouth _____ Nasal obstruction

_____ Gum treatments. When? _____

Are you pleased with the appearance of your teeth? YES / NO

Are there spaces between your teeth that you dislike? YES / NO

Are you satisfied with the color of your teeth? YES / NO

Are you satisfied with the shape of your teeth? YES / NO

Are any of your teeth chipped? YES / NO Where?_____

How often do you brush your teeth? _____

How long do you use a toothbrush before replacing? _____

Have you been diagnosed with Sleep Apnea? YES / NO

Do you like to use Relaxing Gas? YES / NO / Not Tried

DDS Choice: **No Preference** ____ Dr. Curtis ____ Dr. Kent ____

Previous Dentist Name_____

Address OR Phone # _____

Date of last Dental Appointment _____

Date of last X-rays: _____