

New Patient Registration Form

Personal Information

Today's Date _____

Name _____ Date of Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____

Address _____

City _____ State _____ Zip _____

Business Phone _____

Which phone number is your preference for us to contact you _____

Marital Status (single, married, divorced, widowed) _____ Spouse's Name _____ Date of Birth _____

Spouse's Employer _____

Address _____

City _____ State _____ Zip _____

Is the patient a child under the age of 21? _____ What is your most convenient appointment time? _____

Who may we thank for referring you to our office? _____

Tell us about yourself

Yes No

Yes No

- <Are your teeth sensitive to
 - Heat? _____
 - Cold? _____
 - Sweets? _____
 - Biting pressure? _____
- <Does food catch between your teeth? _____
- <Do your gums bleed when brushing? _____
- <Have you noticed any gum swelling? _____
- <Do you have an unpleasant taste or odor odor in your mouth? _____
- <Do you ever avoid any part of the mouth while brushing? _____
- <Have you ever had a reaction to local anesthetic? _____
- <Are you dissatisfied with your teeth and their appearance? _____

- <Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____
- <Do you get frustrated because you always have something to be treated or repaired when you visit the dentist? _____
- <Do you smoke? _____
- <Have you ever had any teeth removed? _____
- <How long have these teeth been missing? _____
- <Do you feel you will eventually wear dentures? _____
- <Do you have any dental fears? _____
- <When was your last dental appointment? Mo _____ Yr. _____
- <What is your present dental problem? _____

Thank you for completing our questionnaire