

PATIENT REGISTRATION

Name:		
Address:		
City:	Prov:	Postal Code:
Phone (home):	Business:	Cell #:
Email:		Birthdate:
I give consent to contact me by email:		PATIENT SIGNATURE
Referred by:		Spouse:

DENTAL INSURANCE

Primary Carrier:			Secondary Carrier:		
Employer:			Employer:		
Insurance Co:			Insurance Co:		
Group#:	Birthdate:		Group#:	Birthdate:	
ID#:			ID#:		
A	B	LIMIT	A	B	LIMIT

DENTAL HISTORY

1. Are you having pain at this time? yes no
2. Are any of your teeth sensitive to: cold sweets heat other _____
3. Do your gums bleed when: brushing flossing
4. Have you ever had any of the following (please circle):
 oral surgery, periodontal treatment, orthodontic treatment, bite adjustment, bite plate
 other appliance (specify): _____

- | | Circle | |
|--|--------|----|
| 5. Have you ever had complications related to dental treatment | yes | no |
| 6. Do you have any dental implants? | yes | no |
| 7. Are you aware of any loose teeth? | yes | no |
| 8. Does food tend to get caught between your teeth? | yes | no |
| 9. Are you satisfied with the the appearance of your teeth? | yes | no |
| 10. Are you nervous about having dental treatment? | yes | no |