DATE _____

PATIENT REGISTRATION & MEDICAL HISTORY

NAME: _____ DATE OF BIRTH _____

ADDRESS: _____

_____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: Single Married Divorced Widowed

HOME TELEPHONE: _____ WORK TELEPHONE: _____

CELL PHONE: _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT (NAME & PHONE NUMBER) _____

INSURANCE POLICY HOLDER: _____

ADDRESS: (if different from above): _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER & WORK ADDRESS: _____

INSURANCE CARRIER/GROUP PLAN: _____

GROUP NUMBER: _____

WHO REFERRED YOU TO THIS OFFICE? _____

DENTAL HISTORY:

DATE OF LAST DENTAL APPOINTMENT? _____

WHAT PROCEDURES WERE PERFORMED: _____

1. Does your jaw click or cause pain on opening and closing? .....YES NO
2. Do you clench or grind your teeth? .....YES NO
3. Do you breathe through your mouth?.....YES NO
4. Do you have an unpleasant taste in your mouth? .....YES NO
5. Are any of your teeth sensitive to: □ Hot? □Cold? □Sweets? □ Pressure?
6. Have you ever had gum treatment or surgery? .....YES NO
7. Do you have a history of a Chemical Dependency ..... YES NO

   If yes, how long in recovery? _____