

# Patient Registration Form

American Dental Association  
www.ada.org

<b>Email:</b>			Today's Date:		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by:		
Name: Last First Middle		Home Phone: <i>include area code</i> ( ) ( )	Cell Phone: <i>include area code</i> ( ) ( )		
Address: Mailing address		City:	State:	Zip:	
SS#:		Date of Birth:	Sex: M F		
Employer:			Business Phone: <i>include area code</i> ( ) ( )		
Emergency Contact:		Relationship:	Home Phone: <i>include area code</i> ( ) ( )	Cell Phone: <i>include area code</i> ( ) ( )	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Please provide school info:			School Name: _____		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2: _____		
Pref. Pharmacy: _____		Phone: ( ) ( )	City, State, Zip: _____		

## Dental Insurance Information

<b>Primary Insurance Information</b>	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
<b>Secondary Insurance Information</b>	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

## Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments? . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			

What is the reason for your dental visit today?

How do you feel about your smile?