REGISTRATION AND DENTAL HISTORY

Name	Single	Married	Long-Term Partner	Divorced	Separated	Widowed
Social Security Number	**Birthdate**	Home phone	Business phone			
Mobile phone	**Email**	**How do you prefer to be contacted by us?**				
Address	City	State	Zip			
Employed by	City	State	Zip			
Present position	**How long held**	Your driver license no.	State			
Spouse/partner's name						
Spouse/partner's Social Security number	**Spouse/partner's birthdate**	Business phone				
Spouse/partner employed by	**City**	State	Zip			
Present position	**How long held**	Spouse Partner's driver license no.	State			
Referred by	Who will pay for this account?					
Credit card name	**Number**	Expiration date				
Name of your dental insurance company	Group number					
Name of your spouse/partner's Insurance company	Group number					

Information given is strictly confidential and will not be released to anyone without your written permission.

YOUR DENTAL HISTORY

Are you having discomfort at this time? _____
How long since you have been to a dentist? _____ Did you have X-rays? _____ How often did you visit before then?_____ Have you lost any teeth?_____ Why?_____ Any complications with extractions?_____ Have they ever been replaced by A fixed bridge_____, Removable Partial_____, Denture_____ Are your teeth sensitive to heat_____, to cold_____, to sweets_____, to sour_____ to chew on_____. Have you had your teeth straightened? _____ When? _____ How often do you brush your teeth?_____
When?_____
How?_____
How long do you use a toothbrush before replacing it? _____ Do you use dental floss?_____ How often? _____
What other cleaning aids do you use? _____
_____ Do you have bleeding gums? _____ When? _____ Have you ever had gum treatments? _____

Do you feel you have bad breath at times?_____
Unpleasant taste in mouth?_____ Any pain in or around your ears?_____ Do you hear popping, clicking or snapping noises when you chew?_____ Do you have any nasal obstruction? _____ Are you aware of any swelling or lump in or around your mouth? _____
Do you now have or have you had any of the following habits: Thumb or finger sucking _____ Cheek or tongue chewing _____ Chewing on Pencils _____ Pens _____ Lip _____ Fingernails _____ Do you have fear of having dentistry done? _____If yes, why? _____
_____ How do you feel about your teeth? _____
_____ Do you have any questions you would like to ask us or concerns about your mouth?_____
_____
_____
_____
_____

Date _____ **Your signature** _____