Patient Registration

Patient's name	Date	of Birth
Sex: Male/Female If minor, name	of legal guardian	
Home Phone: Cell Pho	one: Work	Phone:
Email address:		
Mailing address:	City	StateZIP
Employer		
Spouse/Parent Name	Employer	DOB
Whom may we thank for referring you	to our office?	
INSURANCE INFORMATION: Not C	overed by Dental Insurance	In-Office Membership Plan
PRIMARY DENTAL INSURANCE		
Subscriber: Self Spouse Parer	nt Name	DOB
Subscriber SS#	or Member/Subs	criber ID #
Dental Insurance Co	Group#	Ph#
Claims Address:		
SECONDARY DENTAL INSURANCE		
Subscriber: Self Spouse Parer	nt Name	DOB
Subscriber SS#	or Member/Subs	criber ID #
Dental Insurance Co	Group#	Ph#
Claims Address:		
MEDICAL INSURANCE		
Subscriber: Self Spouse Parer	nt Name	DOB
Medical Insurance Co.	Subscriber ID#	Group#
Claims Address:		

New Patient Dental Questionnaire

How did you hear about our office?			
Date of last dental cleaning visit Previous dentist			
Why are you switching dentists?			
What concerns you most about your mouth?			
What is important to you when you receive dental care?			
How often do you brush your teeth? Floss?			
What do you sip or snack during the day? Ex: (coffee, water, tea, soda, sports drinks, juice, candy, mints)			
Do you smoke, vape or use tobacco? How long?			
Do you have missing teeth?How long?			
Are you happy with the color of your teeth?			
Are you aware of clenching or grinding? If yes, do you wear a guard?			
Have you ever had orthodontics (braces)?			
Have you ever had retainers, partials, dentures or night guard? How long?			
Did you bring these items with you today?			