

# Adult Registration & Health History Questionnaire

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NAME (HUSBAND OR WIFE) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WHAT IS YOUR OCCUPATION? \_\_\_\_\_

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? \_\_\_\_\_ NAME OF INSURANCE COMPANY \_\_\_\_\_

\_\_\_\_\_ POLICY # \_\_\_\_\_

\_\_\_\_\_ UNION (LOCAL #) \_\_\_\_\_ UNION HEAD \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? \_\_\_\_\_ INSURANCE CO. \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ POLICY # \_\_\_\_\_

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT \_\_\_\_\_

\_\_\_\_\_

FOR WHAT COMPANY DO YOU WORK? \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ EXT. \_\_\_\_\_

IF MARRIED, OCCUPATION OF YOUR HUSBAND (OR WIFE) \_\_\_\_\_

FOR WHAT COMPANY DOES HE (SHE) WORK? \_\_\_\_\_

PHONE \_\_\_\_\_ EXT. \_\_\_\_\_

NUMBER OF CHILDREN IN FAMILY \_\_\_\_\_ AGES \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ DRIVER'S LIC. # \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

CELL \_\_\_\_\_ EMAIL \_\_\_\_\_ THANK YOU

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

What treatment was performed at that visit \_\_\_\_\_

What concerns you most about your mouth? \_\_\_\_\_

Have you had any teeth extracted? \_\_\_\_\_

Were you told why your missing teeth should be replaced? \_\_\_\_\_

Check (✓) if you have had problems with any of the following

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in your mouth

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

