Adult Registration & Health Questionnaire

Date:_____

Patients Name: First_____Middle_____Last_____Date of Birth:_____

Home Address: Street_____City_____State_____Zip_____

Home Phone:_____ Cell:_____Work:_____

Best phone number to reach you:_____E-mail:_____

Driver's License #_____

What is your occupation?_____ Employer:_____

Do you have dental Insurance?_____ Insurance company name:_____

Name of policy holder: First_____Middle_____Last_____

Member ID # (Policy holder's ID #)_____Date of Birth of policy holder:_____

Where is policy holder employed?_____**Do you have any additional insurance Y/N**

Name and address of person responsible for payment:_____

_____

(If married) Spouse's name:First_____Middle_____Last_____

Occupation of spouse:_____Employer:_____

Spouse's work phone:_____ Spouse's cell phone:_____

How did you hear about our office?_____Who may we thank?_____

Dental History

Reason for today's visit:_____

Former Dentist:_____

Address:_____

Date of last dental care:_____Date of last full mouth x-rays:_____

What treatment was performed at last visit?_____

What concerns you most about your teeth?_____

Have you had any teeth extracted?_____Were you told why they should be replaced?_____

Are you interested in comprehensive dental care?_____

Do you have any cosmetic concerns?_____

Do you have or have you had any of the following?

☐ **Bad breath**	☐ **Grinding teeth**	☐ **Sensitivity to hot**
☐ **Bleeding gums**	☐ **Loose teeth or broken fillings**	☐ **Sensitivity to sweet**
☐ **Clicking or popping jaw**	☐ **Periodontal treatment**	☐ **Sensitivity when biting**
☐ **Food collection between your teeth**	☐ **Sensitivity to cold**	☐ **Sores or growths in your mouth**

How often do you floss?_____How often do you brush?_____Do you use an electric tooth brush? Y / N