NEW PATIENT REGISTRATION FORM

Name: _____ Today's Date: _____ Date of Birth: _____

Social Security #: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Spouses Name: _____ Address: _____

City: _____ State:_____ Zip Code:_____ Home Phone: _____

Work Phone: _____ Cell: _____ Email: _____

Occupation:_____ Employer Name & Address:_____

_____

Dental Insurance: Yes ☐ No ☐ Name of Insurance: _____

Policy Holder: _____ Policy Holder SS#:_____ Policy Holder's Birthdate:_____

Policy Holder I.D. number _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ Phone #: _____

Person Financially Responsible: _____ Phone: _____

How did you find out about us: (If you were referred by someone please let us know who to thank): _____

Please share with us how you would prefer we contact you. Check one preference or provide an order of preference so we can stay in touch: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail ☐ Text Message

DENTAL HISTORY

1. Please describe the primary reason (s) for your visit (concerns):

   _____

2. How long has this been going on and what would you like done?

   _____

3. Have you ever had a bad experience at a dental visit? ☐No ☐ Yes
   If you answered yes please let us know what we can
   do to make your visit more comfortable. _____

Have you ever suffered from, or been told that you may have any of the following?

☐Gum Disease	☐Bite issues	☐Jaw pain or TMJ
☐Bad Breath	☐Headaches or Migraines	☐Bruxism or Grinding
☐Sleep Apnea	☐Snoring	☐Dental Pain

SMILE EVALUATION

1. Do you like the appearance of teeth, your smile ☐Yes ☐No
   If not, explain _____

2. Are your teeth all in alignment (straight)? ☐Yes ☐No
   If not, explain _____

3. Do you have spaces that you do not like? ☐Yes ☐No
   If not, explain _____

4. Do you like the color of your teeth? ☐Yes ☐No
   If not, explain _____

5. Do you like the shape of your teeth? ☐Yes ☐No
   If not, explain _____

6. Are your teeth……?
   Chipped_____ Protruding_____ Hidden_____

7. Do you like the way that your teeth come together? ☐Yes ☐No

8. Are there old fillings or dental work that you don't like looking at? ☐Yes ☐No
   If not, explain _____

9. What would you like to change the most in the appearance of your teeth? If not, explain

   _____

10. *How would you like your teeth to look?*

    _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting Quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient (or Legal Guardian Signature) Date