dental LOFT

Patient Registration Form

Patient Information:

Name_____ I prefer to be called_____

Address_____City_____State_____Zip_____

Home Phone #_____ Cell Phone #_____ Work Phone #_____ Ext #_____

Sex _____ Marital Status: _____ Birthdate: _____

E-mail: _____

Whom may we thank for referring you? _____

Responsible Party Information: (Person responsible for payment)

Name of Responsible Party_____ Relationship to Patient _____Birthdate _____

(If different than patient)

Address_____City_____State_____Zip_____

Home Phone #_____ Cell Phone #_____ Work Phone #_____ Ext #_____

Insurance Information:

Primary Insurance

Name of Policy Holder _____ Soc.Sec.#_____

Employer_____ Member ID# _____

Name of Dental Insurance Co. _____Group #_____

Secondary Insurance

Name of Policy Holder _____ Soc.Sec.#_____

Employer_____ Member ID# _____

Name of Dental Insurance Co. _____Group #_____

Dental History:

Why have you come to the dentist today? _____

Last visit date: _____ Purpose of last visit: Routine Cleaning / Deep Cleaning / Emergency / Other:_____

Are you in pain? ___Yes ___ No

Your current dental health is ___Good ___Fair ___Poor

Do you brush daily? ___Yes ___No

Have you ever had periodontal disease? ___Yes ___No

Do you have mobility in your teeth? ___Yes ___No

Do you have popping or clicking in your jaw? ___Yes ___No

Do you require antibiotics before dental work? ___Yes ___No

Do you floss daily? ___Yes ___No

Do your gums ever bleed? ___Yes ___No

Are your teeth sensitive to heat, cold, or anything else?_____

Previous/Present Dentist _____City_____

Do you grind or clench your teeth? ___Yes ___No

Are you happy with the way your smile looks? ___Yes ___No

If not, what would you change?_____

Are you interested in any of the following services? (check all that apply)

_____ Veneers

_____ Traditional Braces

_____ Dental Implants

_____ Clear Braces (i.e. Invisalign, Clear Correct)

_____ Cosmetic Whitening

_____ Other _____