Valley Ridge
FAMILY DENTAL

WELCOME

Patient Registration and Dental History

Patient Information

Patient Name _____ Date of Birth _____
Social Security # _____ Marital Status _____
Patient Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
Email address _____ Cell Phone _____
What is the best way to confirm your dental appointments? _____
Patient's employer _____ Present position _____
Spouse's employer _____ Present position _____
Will the fees for our services be offset by dental insurance? Yes / No
Subscriber Name_____ Relationship to patient_____
Name of Dental Insurance Company _____
Identification Number _____ Group Number _____
Who may we thank for referring you to our office? _____

Dental History

Are you aware of any dental problems at this time? _____
How long has it been since you have been to a dentist? _____
What was done then? _____
How often did you visit a dentist before then? _____
Previous Dentist's name _____ Address _____
Have you had any problems or complications with previous dental treatment?
_____

Have you ever had any of the following dental procedures done? If so, please explain.

Gum Treatments or Periodontal Surgery? Yes/No _____
Orthodontic Treatment Yes/No _____
Oral Surgery Yes/No _____
Endodontic Treatment Yes/No _____
Have you ever whitened your teeth? Yes/No Are you interested in whitening? _____
Have you lost any teeth or have any teeth been removed? Yes/No Why? _____

Do you or have your ever experienced any of the following

_____ Hot/Cold Sensitivity
_____ Unpleasant Breath
_____ Bleeding Gums
_____ Food gets caught
_____ Pain or soreness in your face or ear area
_____ Clench or grind your teeth
_____ Difficulty opening or closing
_____ Jaw clicks, pops, or locks
_____ Frequently get cavities
_____ Build up a lot of plaque/calculus

How often do you brush? _____ How often do you floss? _____
What other products/rinses do you use? _____
Do you usually have teeth numbed for dental work? Yes/No
Do you snack or drink liquids (other than water) in between meals? Yes/No How frequently?_____
If you could change anything about your teeth or smile what would that be? _____
Are you planning to keep your remaining teeth your whole lifetime? Yes/No _____
Is there anything we can do to make your dental appointment more comfortable?_____

I certify that the above information is complete and accurate.

Patient/Guardian Signature_____ Date:_____
Dentist's Initials_____ Date:_____

Complete Reverse Side