PATIENT REGISTRATION FORM

Please fill out all of the information below so we can better serve you!

PATIENT'S FULL NAME: Dr. [ ] Mr. [ ] Mrs. [ ] Miss [ ] ______________________________

If patient is a minor, please list parent or legal guardian's name here: ______________________________

DATE OF BIRTH: ____________________ **SOCIAL SECURITY #:** ____________________

WHAT DO YOU LIKE TO BE CALLED: ____________________ **SPOUSE'S NAME:** ____________________

EMERGENCY CONTACT: ______________ **RELATIONSHIP:** ______________ **PHONE:** ______________

INSURANCE (Name, ID #, GROUP #): ______________________________

CONTACT INFORMATION

ADDRESS: Street and House Number: ______________________________

City: ____________________ State: ______________ Zip Code: ______________

PHONE (home):______________ **PHONE (cell):**______________ **PHONE (work):**______________

EMAIL: ____________________ Your email will only be used for administrative, billing, and clinical purposes.

FAMILY PHYSICIAN INFORMATION

PRIMARY CARE DOCTOR: ______________________________ **LAST VISIT:** ______________

LOCATION: ______________________________ **PHONE NUMBER:** ______________

PERSONAL INFORMATION

OCCUPATION: ____________________ **EMPLOYER:** ____________________

HOBBIES (i.e. travel, golf, sewing): ______________________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

[ ] **Yellow Pages / Phone Book**

[ ] **Website**

[ ] **Print Advertisement**

[ ] **Facebook**

[ ] **Referred by a Family Member / Friend / Neighbor**

[ ] **Search Engine** (i.e. Google, Yahoo)

[ ] **Yelp**

[ ] **Another Doctor**

[ ] **Other:** ______________

If you were referred to us by another patient at our office, whom may we thank for the referral?

Referral Source: ______________________________

Thank you for choosing Sieger Family Dentistry!

DENTAL HISTORY FORM

Please fill out all of the information below so we can better serve you!

What is the reason for your visit today? ______________________________

Date of Last Dental Visit? ____________ **Last Dental Cleaning?** ____________ **Last Full Mouth X-rays?** ____________

Previous Dental Practice ______________________ **Telephone Number** ______________________

Teeth

Are any of your teeth sensitive to hot or cold?	Yes	No
Do any teeth hurt when biting or chewing?	Yes	No
Do you grind or clench your teeth?	Yes	No
Have you noticed any shifting of your teeth?	Yes	No
Do your teeth easily chip or break?	Yes	No

Gums

Have you ever been told you have gingivitis?	Yes	No
Have you ever been told you have periodontitis?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth?	Yes	No
Have you noticed any bad tastes or odors?	Yes	No
Do you have any areas where food gets caught?	Yes	No

Jaw

Do you ever experience any jaw or TMJ pain?	Yes	No
Do you wear a night guard or appliance?	Yes	No
Do you ever experience clicking of the jaw?	Yes	No
Any difficulty opening or closing your mouth?	Yes	No

Previous Dental Treatment

Have you ever had orthodontic treatment?	Yes	No
Have you ever had an extraction?	Yes	No
Have you ever had a dental implant?	Yes	No
Have you ever had jaw surgery?	Yes	No
Have you ever had a deep cleaning (scaling)?	Yes	No
Have you ever had periodontal surgery?	Yes	No

Other____________________

Sleep

Have you ever been diagnosed with sleep apnea?	Yes	No
Do you snore loudly?	Yes	No
Do you often feel tired during the daytime?	Yes	No

Other____________________

Miscellaneous

Are you satisfied with your teeth's appearance?	Yes	No
Do you feel nervous from dental visits?	Yes	No
Is it important to keep your teeth your entire life?	Yes	No

Other________

What is your typical dental homecare routine (brushing, flossing, rinses, etc.)? ______________________________

____

Is there any dental procedure you would like to learn more about (fillings, crowns, root canals, implants, etc.)? ________

____

Would you like to learn about how we could improve your smile (straightening teeth, whitening, veneers, etc.)? ______

____

Is there anything else about dental treatment that you would like us to know? ______________________________

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