NEW PATIENT REGISTRATION

Title:	First Name:	Middle Name:	Last Name:	Preferred Name:

Age:	Sex:	Date of Birth:	Marital Status:	Social Security #:	Driver's License State & #:

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Home Address:	City, State, Zip:

Employer's Name:	Employer's Phone:	Occupation:

Best Place/Time to Contact You:	Send Appointment Reminders Via: ☐ TEXT ☐ EMAIL

How did you hear about us? Check all that apply.

☐ Newspaper ☐ Mailer ☐ Drove By ☐ Insurance ☐ Website ☐ Internet Search

☐ Friend or Relative (name): _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone Number: _____

RESPONSIBLE PARTY

Title:	First Name:	Middle Name:	Last Name:	Relation to Patient:

Date of Birth:	Social Security #:	Driver's License State & #:

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Responsible Party Address:	City, State, Zip:

PRIMARY INSURANCE INFORMATION:

Subscriber Name:	Subscriber Date of Birth:	Relation to Patient:	Subscriber SSN:

Member ID #:	Group ID:	Insurance Company Name:	Subscriber Employer:

SECONDARY INSURANCE INFORMATION:

Subscriber Name:	Subscriber Date of Birth:	Relation to Patient:	Subscriber SSN:

Member ID #:	Group ID:	Insurance Company Name:	Subscriber Employer:

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the information to all of my insurance companies. I understand that I am responsible for my bill. I give Renaissance Dental permission to contact me at any/all phone numbers and/or email for the purpose of appointments, treatment, insurance, or payments.

Patient, Parent or Guardian Signature: _____ DATE: _____

DENTAL HISTORY

Patient Name: _____ Birthdate: _____ Age: _____

What is the main reason for your visit today?

- ☐ Tooth Pain
- ☐ Check-up
- ☐ Cleaning
- ☐ Replace Missing Teeth
- ☐ Cavities
- ☐ TMJ/Headaches
- ☐ Cosmetic
- ☐ Chipped/Broken Teeth
- ☐ Straighten Teeth
- ☐ Other: _____

What would you like to learn more about?

- ☐ Cosmetic Dentistry
- ☐ Implants
- ☐ Veneers
- ☐ Bridges
- ☐ TMJ/Headaches
- ☐ Invisalign (orthodontics)
- ☐ Whitening
- ☐ Dentures
- ☐ Other: _____

Please tell us you dental concerns. Check all that apply.

TEETH:

- ☐ Broken or chipped
- ☐ Crooked
- ☐ Decay
- ☐ Difficulty Chewing
- ☐ Cold Sensitive
- ☐ Heat Sensitive
- ☐ Bite Sensitive
- ☐ Sweet Sensitive
- ☐ Loose Teeth
- ☐ Tooth Pain
- ☐ Food Trap Areas
- ☐ Grinding/Clinching
- ☐ Discolored
- ☐ Missing Teeth
- ☐ Orthodontics
- ☐ Loose/Missing Fillings

GUMS:

- ☐ Bad Breath
- ☐ Abscessed
- ☐ Mouth Sores
- ☐ Receding Gums
- ☐ Sore Gums
- ☐ Blisters
- ☐ Bad Taste in Mouth
- ☐ Red (Discolored)
- ☐ Bleeding
- ☐ Swollen
- ☐ Periodontal Treatment

FACIAL/JAW PAIN:

- ☐ Frequent headaches
- ☐ Pain in Temples
- ☐ Pain Around Ear
- ☐ Avoid Certain Foods
- ☐ Ringing in Ears
- ☐ Jaw Injury
- ☐ Popping/Clicking
- ☐ Jaw locks open/closed
- ☐ Biting cheeks/tongue
- ☐ Head Injury
- ☐ Neck/Shoulder Pain

Please rate the following on a scale of 1-5.

1. On a scale of 1-5 (1 not comfortable, 5 very comfortable), what is the level of comfort of your mouth?
2. On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.
3. On a scale of 1-5 (1 not important, 5 very important), how important is it to keep your natural teeth?
4. On a scale of 1-5 (1 never, 5 always), I do what is recommended by my dentist.
5. On a scale of 1-5 (1 low priority, 5 high priority), what is the priority of dentistry for my family and me?
6. On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.
7. On a scale of 1-5 (1 poor health, 5 excellent health), what level of dental health do you desire?

OVER ⟶

DENTAL QUESTIONNAIRE

Last Dental Visit (mm/yyyy): _____ Treatment Complete: ☐ YES ☐ NO

What was done at your last visit? _____

How often do you visit a dentist? _____

Do you brush your teeth? If yes, how often? _____ Do you floss? If yes, how often? _____

1. Is fear an issue for you in a dental office?..... ☐ YES ☐ NO
2. Is time a factor in getting your dental work done? ..... ☐ YES ☐ NO
3. Is the cost of dental treatment a concern for you?..... ☐ YES ☐ NO

If yes, how can we help? _____

Do you have any dental problems, pain, or discomfort at this time? If yes, please tell us your main concerns.

Tell us about your good dental experiences/visits:	Tell us about your bad dental experiences/fears:

What do you like most about your teeth/smile?

Is there anything you don't like about your teeth/smile?

Is there anything you would like to change about your teeth/smile?

What are your short-term dental goals?

What are your long-term dental goals? How would you like your teeth to feel and look?

Is there anything else you feel we should know?