1107 SLIGO CREEK PARKWAY
TAKOMA PARK, MD 20912
301-891-7760

REGISTRATION & DENTAL HISTORY

Patient Name:____ **Date:**____________________________
Last First MI

__Male __Female __Married __Single __Child __Other

Address:____ **City:**________________________ **Zip:** _____________

Home Phone: _________________ **Cell Phone:** __________________**Work Phone:**_______________ **Email:**______________________

Birth Date:____________________ **Social Security #:**_____________________ **Occupation:** __________________________________

Employer:____________________________ **Employer Address:**____

Name of Insured:____ **Is insured a patient?** __Yes __No

Insured's Birth Date: __________________________ **Patient's relationship to insured:** __Self __Spouse __Child __Other ______

Dental Insurance:___________________________________ **ID#:**____________________________ **Group#:**_____________________

Insurance Address: ____

Secondary Insurance:

Name of Insured: ____ **Is insured a patient?** __Yes __No

Insured's Birth Date: ________________________ **Patient's relationship to insured:** __Self __Spouse __Child __Other ______

Dental Insurance:__________________________________ **ID#:**____________________________ **Group#:**_____________________

Insurance Address: ____

Responsible Party's Name on Account: (If different than above) ____

Address: ____

Birth Date: _____________________ **Social Security #:**_________________________ **Phone#:** _______________________________

DENTAL HISTORY (Please answer ALL questions)

Date of Last Dental Visit:______________________ **Reason for this visit:**________________________________

Since your last dental appointment, are there any questions/ problems regarding your dental health you would like answered or discussed? ____

Are you apprehensive about receiving dental treatment? ____
Why? (fear or vibrations, injections, past experiences, etc)____

Have you experienced any discomfort from your teeth lately? ____
If so, where?__________________ **Describe (pressure, temperature change, sweets, etc.)** _________________________

Have you experienced any discomfort from gums lately? ____
Describe ____ **Do they bleed easily?** ________________________________
Have you noticed any discomfort or any unusual changes in the soft tissues of the mouth? (tongue, cheek, throat, lips, etc.)
____

How often do you brush? ______________________________ **Do you use dental floss? (Frequency)**_______________
Are you frequently troubled with bad breath? ____

Do you have any unusual eating habits?____
Do you snack between meals frequently? ____

Does the appearance of your teeth, in any way make you self-conscious? ______________________________________
Explain: ____

Would you like to retain your natural teeth as long as possible?____
If not, explain: ____

Do any of the following apply? (PLEASE CHECK THOSE THAT APPLY)
Popping ____ Snapping noises when you chew_____ Pain when opening wide _____ Discolored teeth _______
Clicking ____ Missing teeth other than wisdom teeth _____ Clenching your teeth____ Frequent headaches ______
Loose teeth____ Have missing teeth been replaced _____ Shifted or tipped teeth ____ Grinding teeth in sleep_____
Loose fillings___ Fillings that have to be replaced often____ Chipped or discolored fillings___ Nerves removed ______

Health Information

Have you ever had any of the following? Please check those that apply:

_AIDS	__Allergies ______	__Arthritis	__Artificial Joints	__Asthma	__Blood Disease
_Cancer	______	__Diabetes	__Dizziness	__Epilepsy	__Excessive Bleeding
_Fainting	__Glaucoma	__Growths	__Hay Fever	__Head Injuries	__Heart Disease
_Heart Murmur	__Hepatitis	__High Blood Pressure	__Jaundice	__Kidney Disease	__Liver Disease
_Mental Disorders		__Nervous Disorders	__Pacemaker	__Pregnancy	__Radiation Treatment
_Respiratory Problems		__Rheumatic Fever	__Rheumatism	__Sinus Problems	__ Stomach Problems
__Stroke	__Tuberculosis	__Tumors	__Ulcers	__Venereal Disease	__Codeine Allergy
__Penicillin Allergy	Other: _______________				

Have you been admitted to a hospital or needed emergency care during the past 2 years? __Yes __No
If yes, please explain: ____

Are you under the care of a physician? __Yes __No
If yes, please explain: ____

Name of Physician: ____

Do you have any health problems that need further clarification? __Yes __No
If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ _____________________________
Signature of patient, parent or guardian **Date**

Referral Information

Whom may we thank for referring you to our practice?____