R.L. Daschbach Dentistry & Associates

Patient Registration: Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE or FEMALE

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_ Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Secuity Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check appropriate box: 🞏 Married 🞏 Single 🞏 Divorced 🞏 Widowed

Spouse or Parent/Guardian’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for your referral?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We offer the following methods of payment. Please check the option you prefer.

🞏 Cash 🞏 Personal Check 🞏 VISA/MASTERCARD/DISCOVER

**Insurance Information**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ID #:\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

How much is your deductible?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Max. Annual Benefit:\_\_\_\_\_\_\_\_\_\_

Do you have any other dental insurance? YES NO If yes, please complete the following:

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ID #:\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

Please turn over...

R.L. Daschbach Dentistry & Associates

**Dental History:**  Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Dentist’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental x-rays:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Are you having any pain discomfort at this time? | YES | NO |
| Do you feel nervous about having dental treatment? | YES | NO |
| Have you ever had a bad experience in the dental office? | YES | NO |
| Is there anything you dislike about your smile? | YES | NO |
| Have you ever had any instructions in oral hygiene? | YES | NO |
| Are there any sores or growths in or around your mouth? | YES | NO |
| Do you have trouble chewing? | YES | NO |
| Does food catch between your teeth? | YES | NO |
| Do you have pain in or near your ears? | YES | NO |
| Do you habitually clench or grind your teeth? | YES | NO |
| Have you ever been told that you have gum problems? | YES | NO |
| Do you have frequent headaches? | YES | NO |
| Have you had a serious injury to your head or mouth? | YES | NO |
| Have you experienced jaw pain?  If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | YES | NO |
| Do you wear dentures or partials?  If yes, date of placement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | YES | NO |
| Do you have missing teeth? | YES | NO |
| If yes, are you interested in having them replaced? | YES | NO |
| Are your teeth sensitive to liquids or foods? (Circle all that apply)  HOT COLD SWEET SOUR | YES | NO |

Is there anything related to your dental history that you have not indicated above?

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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