New Patient Registration

simply smile

Date_____

_____/___/_____M_F_____
Name (Last) (First) (Middle) Date of Birth Sex Social Security Number

_____
Home Address (Street) (City) (State) (Zip Code) Home Phone Number Cell Phone

_____
Name of Employer Occupation Business Phone Drivers License Number

_____/__/_____
Insured Member SSN Date of Birth Insurance Company Relationship Subscriber's Employer

_____
In Case of Emergency (Name, Phone Number, and Relationship of Someone Not at Same Residence)

_____
General Physician Phone Number Address

Dental Health and Appearance

How did you hear about Simply Smile? _____

What are your hobbies? Special interests? _____

Reason for visit? Main concern? _____

Approximate date of last dental visit and reason: _____

When would you like us to start treatment? _____

Have you ever had any serious problems associated with previous dental treatment? _____

_____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you have missing teeth? Y | N If yes, have you had them replaced? Y | N

If you have had missing teeth replaced, are you happy with the results? Y | N

If not, would you like to learn about your options to replace them? Y | N

Do you ever feel (or have been told) that you don't have fresh breath? Y | N

How often do you brush your teeth? _____ How often do you floss? _____

Do you avoid brushing any part of your mouth because of pain? Y | N If yes, what part? _____

Which foods cause you twinges of pain: hot | cold | sweet | sour | none Do you chew on one side of your mouth? Y | N

Do your gums feel tender, swollen, or sore? Y | N Do you have loose or broken fillings or teeth? Y | N

Do you clench/grind your teeth sleeping or during the day? Y | N Do your face muscles ever feel sore/tired? Y | N