## PATIENT REGISTRATION AND HEALTH HISTORY

## PATIENT INFORMATION

Date / /				
Patient's Full Name	Age	Birthdate	1 1	
Address	Age	Dirtilouto		
City	State	Zin	**	
Social Security No				
DENTAL INSURANCE		14	9 . T	
	Date of Birth			
Primary Carrier Insurance Company	Employee	)	· · · · · · · · · · · · · · · · · · ·	
Group No Date Employed	Emp. Social	Security No		
Secondary Carrier Insurance Co.	Employee	)		
Group No Date Employed				
	Date of Bi	rth		
ACCOUNT INFORMATION				
Name of Berney Financially Berneyellets For A				
Name of Person Financially Responsible For Account				
Address	Ct-		7:	
Occupation	Sta	Te	ZIP	
Occupation	City	ployer		
Business Address	OII)	/		
Business Telephone Single	Diversed Wide	· Co	to-d	
Spouse's Name	Spouses Social So	ourity No	parated	
Spouse's Occupation	Spouses Social Se	curity No		
Business Address (Spouse)	Spc	uses Employer		
Business Telephone (Spouse)	Evt			
Person To Contact For Emergency		Phone I	VIO.	
Address City		State	Zin	
Referred to Us By		_ 01010	_ ZiP	
DENTAL HEAD	TH HISTORY			
DENIAL HEAD	LIN HISTORY			
Chief complaint or reason for visit			***************************************	
2. Date of last dental visit	82			
3. Are you experiencing discomfort from your mouth at this time?				
Explain:	ial in all and the	^		
4. Have you had full mouth x-rays (18 x-rays) or a panorex	within the last two year	rs?		
Name and address of dentist where x-rays were taken 5. Circle any of the following which you have had or have a	-t			
Periodontal (gum) treatment		a) dua adma a má		
Endondontic (root canal) treatment	Orthodontic (brace Bleeding sore gum			
Swelling or lumps in mouth		Difficulty opening or closing jaw		
Clenching/grinding		Loose teeth		
Tooth sensitivity to biting		Tooth sensitivity to cold		
Tooth sensitivity to hot	Food impaction			
6. Are you satisfied with the appearance of your teeth?				
7. Does your drinking water contain fluoride?				