Esthetic Design Dental

## New Patient Registration

## Welcome to Esthetic Design Dental

At our office, you will find the best dental care from our highly skilled staff using state-of-the-art dental technology. Please complete the form below so we can get to know you.

Name: _____
First Middle Initial Last

Date of Birth: _____ Social Security Number: _____

Name of Responsible Party (if patient is Minor): _____

Address: _____
Street Apt

_____
City State Zip

Phone: _____ _____ _____
Home Work Mobile

What is the best number and time of day to contact you? _____

Driver's License: _____ Email Address: _____

## Insurance Information

Name of Insured Person: _____ Insured's Date of Birth: _____

Employer: _____ Name of Insured Company: _____

Group Number: _____ Participant Number: _____
May be Insured's SSN

Secondary Insurance (if any): _____

## Emergency Contact Information

Name: _____
First Middle Initial Last Relationship

Phone: _____ _____ _____
Home Work Mobile

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## Dental History

Have you had orthodontic treatment? Yes ☐ No ☐

Are you dissatisfied with the appearance of your teeth? Yes ☐ No ☐

Do you clench or grind your teeth at night? Yes ☐ No ☐

Have you ever had pain in your jaw? Yes ☐ No ☐

Do you have an unpleasant taste in your mouth? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐

Have you had periodontal treatment? Yes ☐ No ☐

Is your mouth sensitive to hot or cold? Yes ☐ No ☐

Does any of your teeth hurt when you bite? Yes ☐ No ☐

When was the last time you were seen by a dentist? _____

When was your last dental cleaning appointment? _____

Have you had full set of x-rays or panoramic x-ray in the last 3 years? Yes ☐ No ☐

If yes, when and where? _____

Have you had any abnormal reactions to local or general anesthesia? Yes ☐ No ☐

Do you require pre-medication with an antibiotic? _____

## Home Care and Habits

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? Yes ☐ No ☐ If Yes, what kind? _____

Do you have an electric toothbrush? Yes ☐ No ☐

Do you snack often between meals? Yes ☐ No ☐

If yes, what kind of snacks and how often? _____

Do you drink sweetened beverages? Yes ☐ No ☐

If yes, what kind of how much per day? _____

Have you ever smoked? Yes ☐ No ☐

If Yes, do you still smoke? Yes ☐ No ☐

If Yes, how many pack per day? _____