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 Security 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?	YES	NO
If yes, please explain:_____		
Do you wear dentures or partials?	YES	NO
If yes, date of placement:_____		
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)	YES	NO
HOT COLD SWEET SOUR		

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

If yes, please explain:_____

_____

_____

_____