Betty Horstmann, DDS

New Patient Registration
Welcome To Our Office!

Today's Date: ___/__/___

Patient Name: _____Preferred Name:_____
Circle One: Male/Female Circle One: Minor/Single/Married/Widowed
Date of Birth: _____Social Security Number: _____
Address: _____
City: _____ State:_____ Zip:_____
Home Phone (___) _____Cell Phone (___)_____
Work Phone (___) _____ Ext:____ May you receive calls **Y/N**
E-mail: (h) _____ (w)_____
Would it be better to contact you via: ___E-mail ___ Cell___ Work___ Home
Do You Have Dental Insurance? YES/NO
Name of Insured and Relationship: _____
DOB: _____ Social Security or ID#:_____
Insured Address if different than patient: _____
Carrier Name: _____ Phone Number (___) _____
Employer: _____ Phone Number (___) _____
Who is financially responsible for balance on account?
Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone Number (___) _____
Are Any Family Members Patients In Our Practice? _____
Please Name: _____
Whom May We Thank For Referring You To Our Office:
_____

Dental History

Please Circle The Appropriate Response:

Does dental treatment make you nervous? **NO/ Somewhat/ Extremely**
Are you having discomfort at this time? **YES/ NO**
Are your teeth sensitive to hot or cold? **YES/ NO**
Have you had treatment for periodontal disease (bone loss)? **YES/ NO**
Do your gums bleed? **YES/ NO**
Do you grind or clench your teeth? **YES/ NO**
Have you ever had TMJ (Temporal Mandibular Joint) pain? **YES/ NO**
Do you smoke? **YES/ NO** Do you chew tobacco? **YES/NO**
Have you ever been shown the proper way to brush and floss your teeth? **YES/ NO**
Date of Last Visit To A Dentist _____
Reason For Today's Visit _____
_____
_____

Please write Name & Phone Number to contact in case of emergency:
_____