NORTH OAKLAND DENTAL GROUP

REGISTRATION FORM

Premed Sticker

Allergy Sticker

Patient Name ______________________________ Date of Birth ________________

Patient would like to be addressed as ____

Cell Phone #____________ Work Phone #____________ Email __________________

Address ________________________ City __________________ State _____ Zip _____

Person responsible for this account _______________ Method of Payment: Insurance CC Cash

Patient/Parent Employed by ____________________ Position ______________________

Business Address ________________________ City ___________ State _____ Zip _____

Do you have dental insurance: Yes No

Dental Insurance ____________________

Subscriber's Name ____________ DOB _____

Subscriber's ID __________ SS # ________

Do you have secondary dental insurance: Yes No

Dental Insurance ____________________

Subscriber's Name ____________ DOB _____

Subscriber's ID __________ SS # ________

Family Members in this practice ____________________ Referred by ________________

Emergency Contact __________________ Relationship ____________ Phone ____________

Do your gums bleed when you brush and floss?	Y N
Are your teeth sensitive to cold, hot, sweets?	Y N
Do you have or experience dry mouth?	Y N
Have you ever had periodontal treatment?	Y N
Have you ever had orthodontics (braces)?	Y N
Have you ever had difficulty getting numb?	Y N
Do you have earaches or neck pain?	Y N
Do you have clicking or popping in jaw?	Y N
Do you clench or grind your teeth?	Y N
Do you wear dentures or partials?	Y N
Do you have sores or ulcers in your mouth?	Y N
Have you ever had an injury to head or mouth?	Y N

Are you currently experiencing any dental pain or discomfort? Explain ____________________

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When was your last dental visit? ______________

How do you feel about your smile? ______________

What is the reason for your visit today? ______________

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Patient or Guardian's Signature ____________________________ Date ________________