

DENTAL HISTORY

Orvis J. R. Johnson, D.D.S. • 825 Prospect Ave. • North Fond du Lac, WI 54937

Patient Name _____ Date _____

Wishes to be called _____

Primary Initial Concern _____

Previous Dentist _____ Date of Last Visit _____

Reason for leaving _____ Date of last full mouth x-rays _____

_____ Date of last cleaning _____

How often do you visit a dentist? _____

How often do you have your teeth cleaned? _____

Have you ever had:

Gum disease or pyorrheaYes No
Any loose teethYes No
Any gum pain or swellingYes No
Bleeding when you brushYes No
Food lodging between your teethYes No
Periodontal (gum) surgeryYes No
Instructions on tooth brushingYes No

Oral SurgeryYes No
Endodontic (Root Canal) TherapyYes No
Orthodontic TreatmentYes No
Treatment for TMJ problemsYes No
Your teeth ground or bite adjustedYes No
Worn a TMJ applianceYes No
Clicking or noise in your jawYes No
Pain in your jaw or earYes No
Pain during chewingYes No

Pain during opening or closingYes No
Difficulty in opening or closingYes No
Any injury to jaw, head or neckYes No
Chewing difficultyYes No
History of headachesYes No

How frequently _____

Are your teeth sensitive to: Hot Cold Sweet

Do you have any of the following habits:

Grind or clench your teethYes No
Bite your nailsYes No

When _____

Hold objects with your teethYes No

What _____

Mouth breath while awake/asleepYes No

Smoke or chew tobaccoYes No

Drink coffee or teaYes No

How do you feel about having dental treatment done? Have you ever had an uncomfortable dental treatment experience? Please describe: _____

How do you feel about the appearance of your teeth? _____

Do you feel it is important to keep your teeth? _____

Would you be interested in learning if you are a candidate for tooth whitening? _____

Is there anything that you would like to change about your smile? _____

Is there anything else you feel we should be aware of? _____

PATIENT REGISTRATION FORM

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Date _____ Referred by _____
Patient Name _____ Sex - M F Marital Status - S M D W
Wishes to be called _____ DOB _____
Address _____ SS # _____
City _____ State _____ Zip+4 _____ Home Ph _____
E-mail Address _____ Cell Ph _____
Employer _____ Work Ph _____
Spouse Name _____ Spouse SS # _____
Emergency Contact Name/Phone _____

PERSON RESPONSIBLE FOR THIS ACCOUNT - If Patient is responsible party check here

Responsible Party's Name _____ Relationship to Patient _____
Address _____ SS # _____
City _____ State _____ Zip+4 _____ Home Ph _____
Employer _____ Work Ph _____

FOR PATIENTS COVERED BY INSURANCE

Primary Dental Insurance -

Please Note: We will only consider your primary insurance when computing estimates and making financial arrangements.

Subscriber's Name _____ SS # _____
DOB _____ Employee I.D.# _____ Patient's Relationship to Subscriber - Self Spouse Dependent
Employer _____ Business Ph _____
Business Address _____
Dental Insurance Company _____ Group # _____
Deductible Met? - Yes No Max. Benefit \$ _____ Benefit Year _____
Have you used your Dental Insurance this benefit year? - Yes No
Are you covered under more than one (1) Dental Plan? - Yes No (If yes, please complete next section)

Secondary Dental Insurance -

Please Note: Submission to any secondary dental insurance, or your medical insurance is your responsibility. We recommend that you keep a copy of your explanation of benefits (EOB) sent to you by your primary insurance company. Your secondary insurance and/or medical insurance company will require you to send a copy of your primary insurance EOB before they determine payment.

Subscriber's Name _____ SS # _____
DOB _____ Employee I.D.# _____ Patient's Relationship to Subscriber - Self Spouse Dependent
Employer _____ Business Ph _____
Business Address _____
Dental Insurance Company _____ Group # _____
Deductible Met? - Yes No Max. Benefit \$ _____ Benefit Year _____
Have you used your Dental Insurance this benefit year? - Yes No

The above information is accurate and complete and to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party: _____ Date: _____

Please complete other side 