Back to Basics Dental Center, L.L.C.
D.B.A. Back 2 Basics Dentistry

New Patient Registration

Patient Name:	Last Name:	MI:	Preferred Name:

Street Address:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Date of Birth:	Age:	Social Security #	Driver's License #

May We Contact You Via?	Sex	Marital Status
Text ☐ Email ☐ Both ☐	Male ☐ Female ☐	Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Responsible Party (if Other Than The Patient)

Patient Name:	Last Name:	MI:	Preferred Name:

Street Address:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Insurance Information

Name of Insured:	Relationship
	Self ☐ Spouse ☐ Child ☐ Other ☐ (if other)

Insured Social Security #	Date of Birth:	Employer:	Insurance Company:

Employer Street Address:	City:	State:	Zip:

Dental Questionnaire

Date of Last Dental Exam:	Date of Last Dental Cleaning:	Are you experiencing any pain or sensitivity with any of your teeth?
		Yes ☐ No ☐ If Yes, for how long?

Have you tried anything to help with the pain / sensitivity?	Is there anything specific you would like us to focus on today?
Yes ☐ No ☐ If Yes, how is it working?	

On a Scale of 1 – 10, with 10 being the best, how would you rate your overall smile and condition of your teeth?	What would you like them to be?	Who may we thank for your referral to our office?

Please check if you have had any of the following

- ☐ Bad breathe
- ☐ Bleeding gums
- ☐ Blisters on gums or lips
- ☐ Burning sensation with tongue
- ☐ Chewing or fingernails or objects
- ☐ Clicking or popping in your jaw
- ☐ Dry Mouth
- ☐ Food collection in between teeth
- ☐ Grinding of teeth
- ☐ Gums swollen or tender
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Gum surgery
- ☐ How often do you brush? _____
- ☐ How often do you floss? _____

Emergency contact person: _____ Phone #_____