DR. BAICY, DMD
Health History & Registration

Date: _____

PATIENT INFORMATION

Name: Last_____ First_____ MI____ Preferred Name: _____ Sex: M/F
Birthdate: _____ Marital Status: _____ Soc Sec. # _____- _____-_____
Employer: _____Occupation _____
Referred by: Existing Pt:_____ Internet: Direct Mailer: Other: _____
Mailing Address: _____Apt #_____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work:_____
Email: _____
Preferred Confirmation: Home Cell Email Text Work

RESPONSIBLE PARTY INFORMATION

Same as Above:
Name: Last _____ First_____ MI_____ Marital Status: _____
Relationship to Pt: _____
Soc Sec. # _____- _____-_____ Birthdate: _____ Age: _____
Mailing Address: _____Apt #_____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work:_____

DENTAL INSURANCE

Primary Ins

Insured's Name: _____
Ins. Co: _____ Phone: _____
Ins. Address: _____
Insured Employer: _____
Insured's Social Security #_____
Group # _____

Secondary Ins.

Insured's Name: _____
Ins. Co: _____ Phone: _____
Ins. Address: _____
Insured Employer: _____
Insured's Social Security #_____
Group # _____

DENTAL INFORMATION

Dental History	Yes	No
Are you having any dental problems now? If yes, what? _____		
Do your gums bleed when you brush or floss?		
Is your mouth dry?		
Are you apprehensive about dental treatment?		
Have you had a deep cleaning before (usually 2 visits numbing required)?		
Are you unhappy with the appearance of your teeth?		
Do you have headaches, neck pain, or earaches?		
Have you worn Braces before? (orthodontics)		
Are your teeth sensitive to hot, cold, sweets, pressure?		
Do you have discolored teeth that bother you?		
Would you like your smile to LOOK BETTER or DIFFERENT?		

How long has it been since you've last seen a dentist? _____