West Village Dental Studio
Family and Cosmetic Dentistry

Patient Registration

Patient's name _____ Preferred name _____

Date of Birth_____Cell phone _____ Work phone _____

Email: _____

Preferred Method of Contact: ❑ Phone ❑ Email ❑ Both

Mailing address _____

City _____State _____ Zip _____

Employer _____

Occupation _____Your Social Security Number:_____

How did you hear about us? _____

Insurance Information: ❑ Not covered by dental insurance

Dental Insurance Co._____

Member is: ❑ Myself ❑ Spouse ❑ Mother ❑ Father

Member's Social Security or Member ID number: _____Group number_____

Member's Date of Birth: _____Member's Employer_____

Dental History

Reason for today's visit:_____Date of last dental visit:_____

Former Dentist:_____ Date of last dental x-rays_____

Please check if you have/had

	Yes	No
Bad Breath	❑	❑
Chew on one side of mouth	❑	❑
Food collection between teeth	❑	❑
Jaw pain	❑	❑
Loose or broken fillings	❑	❑
Current or past braces	❑	❑
Gum therapy	❑	❑
Blisters on lips or mouth	❑	❑
Dry mouth	❑	❑
Clench or grind teeth	❑	❑
Swollen/bleeding gums	❑	❑
Mouth breathing	❑	❑

	Yes	No
Tooth sensitivity (cold, hot, sweet)	❑	❑
Dental anxiety/fear	❑	❑
Aggressive brushing	❑	❑
Are you happy with your smile?	❑	❑
Would you like to discuss options on:		
Whitening your teeth	❑	❑
Straightening your teeth	❑	❑
Brushing/flossing techniques	❑	❑

How often do you brush? _____ time(s) per day

How often do you floss? _____