PEDDICORD
FAMILY DENTISTRY
ERIKA E. PEDDICORD, D.D.S., P.L.C.

WELCOME

Patient Registration and Dental History

Patient Information

Patient Name _____ Date of Birth _____
Social Security # _____ Marital Status _____
Patient Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
Email address _____ Cell Phone _____
Emergency Contact Name and Number _____
What is the best way to confirm your appointments? _____
Patient's employer _____ Present position _____
Spouse's employer _____ Present position _____
Will the fees for your care be offset by dental insurance? Yes / No
Subscriber Name_____ Relationship to patient_____
Subscriber DOB: _____Name of Dental Ins. _____
Identification Number _____ Group Number _____
Who may we thank for referring you to our office? _____

Dental History

Are you aware of any dental problems at this time? _____
How long has it been since you have been to a dentist? _____
What was done then? _____
Previous Dentist's name _____ Address _____
Have you had any problems or complications with previous dental treatment? _____
Have you ever been told to take antibiotics prior to your dental appointment? Yes/No _____

Have you ever had any of the following dental procedures done? If so, please explain.

❑Yes ❑No Perio Therapy or Scaling & Root Planing
❑Yes ❑No Endodontic or Root Canal Treatment
❑Yes ❑No Dental Implants Placed
❑Yes ❑No Orthodontic Treatment
❑Yes ❑No Oral Surgery

Have you ever whitened your teeth? Yes/No Are you interested in whitening? _____
Have you lost any teeth or have any teeth been removed? Yes/No Why? _____

Do you experience any of the following:

❑Yes ❑No Hot/Cold Sensitivity
❑Yes ❑No Unpleasant Breath
❑Yes ❑No Bleeding or Tender Gums
❑Yes ❑No Food gets caught easily
❑Yes ❑No Frequently get cavities
❑Yes ❑No Clench or grind your teeth
❑Yes ❑No Difficulty opening or closing
❑Yes ❑No Jaw clicks, pops, or locks
❑Yes ❑No Pain or soreness in your face or by your ear
❑Yes ❑No Build up a lot of plaque/calculus
❑Yes ❑No Eat or drink frequently between meals

How often do you brush? _____ How often do you floss? _____
What other products, rinses, or home remedies do you use? _____
Do you usually have teeth numbed for dental work? Yes/No _____
If you could change anything about your teeth or smile what would that be? _____
Are you planning to keep your remaining teeth your whole lifetime? Yes/No _____
Is there anything we can do to make your dental appointment more comfortable?_____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date:_____
Dentist's Signature _____ Date:_____