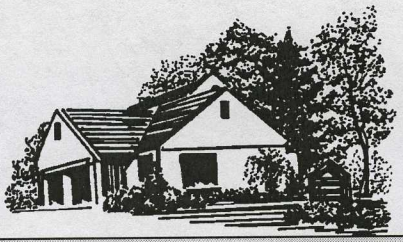

# PERSONAL REGISTRATION

Hendricks Family Dentistry, Inc.
4181 Center Road
Brunswick, OH 44212
Phone 330-225-1433

**This personal information will help us to give you the most consideration of your time and feelings. It is important to have complete answers. All information, of course, is confidential.**

Today's Date_____

Your Name:_____ Date of Birth:_____

Spouse's Name:_____

Home Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____ Social Security #:_____

Place of Employement:_____ Occupation:_____ Phone:_____

Work Address:_____

Are you covered by any kind of dental insurance?_____ Carrier:_____ Policy Holder's Birth Date:_____ Group No._____

Social Security # of Spouse:_____ Driver's License Number:_____

Spouse's Place of Employement/Occupation: _____

Phone:_____

Secondary Insurance carrier:_____ Policy Holder's Birth Date:_____ Group No._____

May we ask who recommended this office?_____

## DENTAL HEALTH

Reason for visit_____

Are you having any discomfort or pain?_____ Yes ❑ No ❑ When was your last dental visit?_____

What was done for you at that time?_____

Have you ever had any serious problem associated with previous dental treatment? Yes ❑ No ❑

If so, explain:_____

How often do you brush your teeth?_____ How often do you floss?_____

What texture brush do you use? Soft_____ Medium_____ Hard_____ Nylon_____

1. How do you feel about your teeth?
   _____
2. Are you happy with the way they look?
   _____
3. Are your teeth comfortable? Do you feel pain when brushing or flossing?
   _____
4. Does any area bother you when you chew? (Explain, if so)
   _____
5. If you could change anything in your mouth, what would it be?
   _____
6. Is there anything about previous dental experiences you would like to tell me?
   _____
7. Has treatment you have had done in the past been comfortable?
   _____
8. Do you feel the treatment you have had done in the past was of lasting value?
   _____

| | | | | |
|---|---|---|---|---|
| Do your gums bleed while brushing or flossing? | Yes | ❑ | No | ❑ |
| Are your teeth sensitive to hot, cold or sweets? | Yes | ❑ | No | ❑ |
| Do you clench or grind your jaws while sleeping or during the day? | Yes | ❑ | No | ❑ |
| Do your jaws ever feel tired? | Yes | ❑ | No | ❑ |
| Do you gag easily? | Yes | ❑ | No | ❑ |