DR. COURTNEY J. LAM, DMD
FAMILY AND COSMETIC DENTISTRY

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PATIENT REGISTRATION

TODAY'S DATE:

NAME: MALE ☐ FEMALE

ADDRESS: CITY: STATE: ZIP:

DOB: SS:

HOME PHONE: WORK PHONE: CELL PHONE:

EMAIL:

EMERGENCY CONTACT: EMERGENCY CONTACT PHONE NUMBER:

PERSON FINANCIALLY RESPONSIBLE:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: WORK PHONE: CELL PHONE:

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY:

WHO IS THE INSURANCE THROUGH? ☐ SELF ☐ SPOUSE

SPOUSE FULL NAME: SPOUSE DOB:

SUBSCRIBER/MEMBER ID#: GROUP #:

EMPLOYER: (PLEASE PROVIDE INSURANCE CARD)

DENTAL HISTORY

ARE YOU PRESENTLY IN DISCOMFORT? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE

DO YOU HAVE DENTAL FEARS? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE

ARE YOU DISSATISFIED WITH YOUR TEETH & THEIR APPEARANCE?

HOW OFTEN DO YOU BRUSH YOUR TEETH?

HOW OFTEN DO YOU FLOSS YOUR TEETH?

DOES ANYONE IN YOUR FAMILY HAVE GUM DISEASE? ☐ YES ☐ NO

DO YOUR GUMS BLEED WHEN YOU BRUSH? ☐ YES ☐ NO

DO YOU HAVE SWELLING AROUND ANY TEETH? ☐ YES ☐ NO

DO YOU NOTICE A BAD TASTE OR ODOR? ☐ YES ☐ NO

ARE YOUR TEETH SENSITIVE TO (CHECK ALL THAT APPLY) ☐ HOT ☐ COLD ☐ SWEET ☐ BITING PRESSURE

HAVE YOU NOTICED ANY JAW PROBLEMS LIKE ☐ CLICKING ☐ PAIN ☐ CLOSING ☐ OPENING ☐ CHEWING

ARE YOU CONCERNED ABOUT THE FINANCES REQUIRED TO GET YOUR TEETH TO EXCELLENT DENTAL HEALTH? ☐ YES ☐ NO

DO YOU GET FRUSTRATED BECAUSE YOU ALWAYS NEED SOMETHING TO BE TREATED OR REPAIRED AT THE DENTIST? ☐ YES ☐ NO

WHY DID YOU LEAVE YOUR LAST DENTIST?