

Boyle Heights Dental Care
2206 E. Cesar E. Chavez Ave
Los Angeles, CA 90033
323-265-3680

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		Yes	No
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Tooth sensitivity (cold, hot, sweet)	<input type="checkbox"/>	<input type="checkbox"/>
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Dental anxiety/fear	<input type="checkbox"/>	<input type="checkbox"/>
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Aggressive brushing	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Loose or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>			
Current or past braces	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to discuss options on:		
Gum therapy	<input type="checkbox"/>	<input type="checkbox"/>	Whitening your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Straightening your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Brushing/flossing techniques	<input type="checkbox"/>	<input type="checkbox"/>
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>			
Swollen/bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____ time(s) per day		
Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____		