WELCOME

DR. "DAVE" KNAUS

NEW PATIENT REGISTRATION

DATE _____

PATIENT'S FULL NAME _____ M/F ____ NICK NAME _____ AGE _____ DATE OF BIRTH _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT/GUARDIAN ACCOUNT INFORMATION

FATHERS NAME: _____
ADDRESS: _____
PHONE (HOME): _____
(CELL): _____ (WORK): _____
E-MAIL: _____
EMPLOYER: _____
ADDRESS: _____
DENTAL INS. CO.: _____
INS. ADDRESS: _____
MEMBERSHIP/POLICY#: _____
SOCIAL SECURITY #: _____
DATE OF BIRTH: _____
PERSON FINANCIALLY RESPONSIBLE: _____

MOTHERS NAME: _____
ADDRESS: _____
PHONE (HOME): _____
(CELL): _____ (WORK): _____
E-MAIL: _____
EMPLOYER: _____
ADDRESS: _____
DENTAL INS. CO.: _____
INS. ADDRESS: _____
MEMBERSHIP/POLICY#: _____
SOCIAL SECURITY #: _____
DATE OF BIRTH: _____
RELATIONSHIP: _____

PLEASE TELL US HOW YOU HEARD OF OUR PRACTICE _____

(We would like to thank them)

DENTAL HISTORY

Reason for visit: ❑ Routine Care ❑ Orthodontic Care
Specific Concerns: _____
Is this the first dental visit? (Yes or No): _____
If No, previous dentist's name: _____
Date of last visit: _____

	YES	NO
Has child complained about dental problems _____	❑	❑
Any unhappy dental experiences _____	❑	❑
Any injuries to mouth-teeth-head _____	❑	❑
Any mouth habits-thumbsucking, nail biting, mouth, breathing nursing bottle habits, pacifier, sippy cup, etc. _____	❑	❑
Any unusual speech habits _____	❑	❑
Any lost teeth _____	❑	❑
Do you desire complete dental service for the child? ____	❑	❑

Child's attitude of dentistry _____

	YES	NO
Have missing teeth been replaced _____	❑	❑
Orthodontic appliances worn now or ever been _____	❑	❑
Parents ever wear braces _____	❑	❑
Does your child brush daily _____	❑	❑
Does your child use toothpaste _____	❑	❑
Do you assist child with tooth brushing _____	❑	❑
How often _____	❑	❑
Is dental floss used _____	❑	❑
How often _____	❑	❑
Family history of gum disease _____	❑	❑
Parents' history of dental decay _____	❑	❑
Parents' history of dental decay _____	❑	❑
Do you have well or city H2O _____	❑	❑
Does you child take flouride supplements _____	❑	❑

Parents' attitude toward dentistry _____

PLEASE COMPLETE REVERSE SIDE ALSO