Bergmann and Hohm Dental Group
N50 W34770 Wisconsin Avenue ◆ Okauchee, WI 53069 ◆ 262-567-0770

Dental Registration

Today's Date: _____

Patient's Name: _____ Nickname: _____
Last First MI

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____)_____ Work/Alternative Phone: (_____)_____

Email: _____

Sex: M F Age: _____ Date of birth: _____ Marital Status: _____ SS#: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: (_____)_____ Work/Alternative Phone: (_____)_____

Whom may we thank for referring you to our office? _____

Insurance Information

Primary

Policy Holder's Name: _____ SS#: _____

Relationship to Patient: _____ Date of Birth: _____

Insurance Co.: _____Group #: _____ Member #: _____

Employer Name: _____ Phone: (_____)_____

Secondary

Policy Holder's Name: _____ SS#: _____

Relationship to Patient: _____ Date of Birth: _____

Insurance Co.: _____Group #: _____ Member #: _____

Employer Name: _____ Phone: (_____)_____

Dental Information

Answers to the following questions are for our records only and will be considered confidential.

	yes/no
Do you have active tuberculosis?	☐ ☐
Do you have a persistent cough greater than a three (3) week duration?	☐ ☐
Do you have a cough that produces blood?	☐ ☐
Have you been exposed to anyone with tuberculosis?	☐ ☐
Do your gums bleed when you brush or floss?	☐ ☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐ ☐
Does food or floss catch between your teeth?	☐ ☐
Is your mouth dry?	☐ ☐
Have you had any periodontal (gum) treatments?	☐ ☐
Have you had any orthodontic (braces) treatments?	☐ ☐
Have you had any problems with previous dental treatment?	☐ ☐
Is your home water supply fluoridated?	☐ ☐
Do you drink bottled or filtered water?	☐ ☐

If yes, how often?
Circle one: DAILY / WEEKLY / OCCASIONALLY

	yes/no
Are you currently experiencing any dental pain or discomfort?	☐ ☐
Do you have earaches or neck pains?	☐ ☐
Do you have any clicking, popping or discomfort in the jaw?	☐ ☐
Do you brux or grind your teeth?	☐ ☐
Do you have sores or ulcers in your mouth?	☐ ☐
Do you wear dentures or partials?	☐ ☐
Do you participate in active recreational activities?	☐ ☐
Have you ever had a serious injury to your head or mouth?	☐ ☐

How do you feel about you smile?

Date of you last dental exam:
What was done at that time?

What is the reason for your dental visit today?

Date of last dental x-rays: