Dr. Malcolm Walters Jr. & Associates
HOME OF THE
PERFECT SMILE

PATIENT REGISTRATION

Today's Date _____ Last Name _____ First Name _____ MI _____ Date of Birth _____ Age ____

Sex (Please Circle): Male Female Other _____

Please Circle One: Single Married Separated Widow
Mailing Address: _____ City _____
State ____ Zip Code _____ Email _____
Home Phone (_____)_____ Cell Phone (_____)_____
Occupation _____
Are you a full time student? Yes or No If patient is a minor:
Emergency Contact _____ Relationship _____ Phone # (_____)_____ If you are filling this form out on behalf of another person, what is your relationship to that person? Name _____
Relationship _____ Reason for today's visit?
_____

How did you hear about us? ¨ **In-home Mailer** ¨ **Social Media** ¨ **Insurance** ¨ **Practice Website** ¨ **Internet** ¨ **Family/Friend/Coworker** ¨ Other_____

Who can we thank for your visit? _____

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete X-rays _____/_____

When was your last dental appointment? _____

Why did you leave your previous dentist?
_____
_____

Name of your previous dentist? _____

Do your Gums bleed when brushing? ( ) Yes ( ) No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? ( ) Yes ( ) No

Does dental treatment make you nervous? ( ) Very ( ) Moderately ( ) Slightly ( ) No

If I cloud change my smile I would make my teeth ( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

Other concerns/needs of mine are:
_____
_____
_____
_____