Blue Ridge Family Dental
Rachael Schuette D.D.S.

Welcome! We know how important it is to feel comfortable and confident with your choice of dental care providers. We can assure you that we will take the time to listen to your needs and do what we can to provide quality dentistry in a relaxed, family-oriented environment with a commitment to your overall oral health. Please fill out our patient registration forms as completely as possible so that we may get to know you better and provide you and your family the best care possible.

Patient Information

Last Name: _____ First (Legal) Name: _____ MI: _____

Date of Birth: _____ Age: _____ Social Security #_____ Sex: M F

Preferred Name: _____ Home Phone:_____ Cell Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Email Address: _____ Preferred Contact Method: __Phone __ Email __Text

Drivers License # _____ Marital Status: __ Married __ Single __Divorced __Separated

Employer: _____ Work Phone: _____ Extension: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

How did you hear about our office? _____ Referred By: _____

Emergency Contact: _____ Emergency Contact Phone #_____ Relationship: _____

Responsible Party Information

Last Name: _____ First (Legal) Name: _____ MI: _____

Relationship to Patient: ___ Parent ___Spouse ___Self ___Other Sex: M F

Address:_____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security # _____ Drivers License # _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Dental Insurance Information

Name of Insured (Policy Holder): _____ Insured's Date of Birth: _____

Insured Social Security # _____ Insured Relationship to Patient: _____

Insured's Employer: _____ Insurance Company: _____

Subscriber ID: _____ Group Number: _____ Insurance Phone # _____

Claims Mailing Address: _____ City: _____ State: _____ Zip: _____

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Dental History

What brings you in to see us today? _____

Check all additional dental concerns:
__Cleaning __Tooth Pain/swelling __Sensitivity __Broken Tooth/Teeth __Cavities
__Gum Concerns __Missing Teeth __Cosmetic Concerns __ Whitening
__Other/Additional Comments: _____

If you have treatment needs, are you interested in having treatment completed today? _____

When was your last dental visit? _____ When was your last dental cleaning? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have a history of gum/periodontal disease that has required a "deep cleaning" or "scaling and root planing?" __ Yes __ No If yes, when was your last scaling and root planing? _____

Do your gums bleed? __ Yes __ No

Do you like the appearance of your teeth? __ Yes __ No. If no, what changes would you like to make about your teeth? _____
_____

Do you have a history of orthodontic care (braces)? __ Yes __No

Do you feel as though you clench or grind your teeth? __ Yes __ No
Do you wear a bite guard? __ Yes __ No If Yes, how old is your current guard? _____

Do you have any dental related anxiety? __ Yes __ No. If yes, is there anything we can do to make you feel more comfortable during treatment? _____
Is there anything we should avoid during treatment? _____

If you are a candidate, are you interested in nitrous oxide (laughing gas) for your dental treatment?
__ Yes __ No

What are your main concerns when considering dental treatment?
__ Quality of treatment __ Cost __ Cleanliness __ Location __ Staff Friendliness
__ Comfort __ Other: _____

Is there any additional information you would like for us to know about you? _____
_____
_____

Signature of Patient/Parent or Guardian: _____ Date: _____