Thank you for selecting our smile team! We strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely. If you have any questions or need assistance, please ask. We will be happy to help.

PATIENT INFORMATION

Name_________________________________ Birth Date______________ SS#_____________________

If under 18, Parent/ Guardian ___________________________________ Minor☐ Single☐ Married ☐Other☐

Home Address ___________________________ City _________________ State_______ Zip __________

Home Phone______________________________ Cell Phone___________________________________

Email Address _______________________________________ Drivers License #_______________________

Preferred method of contact: Email ☐ Phone Call ☐ Text Message ☐ Postcard ☐

Patient or Parent Employer _____________________________________ Occupation_____________________

Work Phone ___________________________ Ext.__________ How long Employed?___________________

Ideal time for appointments____

Name of school patient attends____

Emergency Contact ____________________________________ Phone_______________________________

SPOUSE INFORMATION OR PARENT INFORMATION

Name_________________________________

Employer______________________________

Work Phone ______________________ Ext _____

Cell Phone_______________________________

Birth Date ________________________________

SS# _____________________________________

HOW DID YOU FIND OUT ABOUT US?

Whom may we thank for referring you to all About Smiles?

____

What other ways have you heard about us?

- Sign/Location
- Telephone Directory
- Coupons
- Business Card
- Newspaper
- Mailing
- Internet Search
- Website/Facebook

DENTAL QUESTIONS

How may we help you today?____

Do you have any dental concerns?____

Are you currently in pain?____

How do you feel about the appearance of your teeth?____

What is the main reason for your visit today? ☐ Tooth Pain ☐ Check up ☐ Teeth Whitening ☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Orthodontic (braces) ☐ Other- If other, please list: ____________________

Do you want to have regular dental cleanings? ____

DENTAL HISTORY

Previous dentist______________________________ Location______________________________

Date of last dental care ______________________________ Date of last dental x-rays ____________________

On a scale of 1 to 5 (1 being bad, 5 being good) please rate how you feel your overall dental health is: 1 2 3 4 5

On a scale of 1 to 5 (1 being bad, 5 being good) over the last 5 years rate how faithfully you have had your teeth cleaned: 1 2 3 4 5

On a scale of 1 to 5 (1 being bad, 5 being good) what is your level of sensitivity to a teeth cleaning: 1 2 3 4 5

On a scale of 1 to 5 (1 being bad, 5 being good) what is your level of sensitivity to dental treatment: 1 2 3 4 5

Please check the circle if you have had any of the following:

- ○ Bad Breath
- ○ Bleeding Gums
- ○ Clicking or Popping Jaw
- ○ Collecting Food Btwn Teeth
- ○ Suffer from Headaches
- ○ Currently wearing CPAP or diagnosed with Sleep Apnea
- ○ Grinding Teeth
- ○ Loose Teeth
- ○ Periodontal Treatment
- ○ Sores in Your Mouth
- ○ Sensitivity to Heat
- ○ Sensitivity to Sweets
- ○ Sensitivity to Cold
- ○ Sensitivity When Eating
- ○ Dry Mouth
- ○ Snoring

How often do you Floss? ____________________How often do you Brush? ____________________

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? If yes, please explain.

____