A PLACE TO SMILE

We would like to get to know you better!

What do you see for your teeth in 5- 10 years?_____
Personal Notes:_____ Favorite Restaurant:_____
Name:_____ Male ( ) Female ( ) Date:_____
Address:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work:_____
Would you like to receive email ( ) or text message ( ) reminders and discounts?
Email Address:_____
Whom can we thank for referring you to our office?_____
Date of Birth:_____ Occupation:_____

General Health Questions:
Are your teeth sensitive to: Heat, Cold, Biting Pressure or Sweets?_____
Does food catch between your teeth?_____ Any Odors?_____
Do your gums bleed when you brush?_____ Any Swelling?_____
Any jaw problems: Clicking, Pain, Difficulty opening, closing or chewing?_____
Have you ever had a reaction to the local anesthetic?_____
Do you smoke?_____
Have you had your wisdom teeth removed?_____ When?_____
When was your last thorough dental examination?_____ Pano?_____
Are you under a physicians care or do you have any general health conditions?_____
Current Medications:_____
Have you had surgery?_____
To the best of your knowledge have you been afflicted with : (please circle)

Heart Ailment	Epilepsy
Diabetes	High Blood Pressure
Rheumatic Fever	Respiratory Disease
Hepatitis	HIV Positive
Prolonged Bleeding	Healing Complications

Do you have any drug or latex allergies?_____
Why did you leave your last dentist?_____

Signature:_____Date:_____