



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 us. 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 Orthodontics (braces) Other – If other, please list: _____

What would you like to learn more about? Routine Check ups Teeth Whitening Cosmetic Dentistry

Sedation Dentistry Orthodontics (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 if you have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Collection Food Btwn Teeth | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitivity When Eating |
| <input type="checkbox"/> Suffer from Headaches | <input type="checkbox"/> Sores or Growths in Your Mouth | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Currently wearing CPAP or diagnosed with Sleep Apnea | | <input type="checkbox"/> 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.

I have reviewed this questionnaire and answered its questions, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any changes in my health status should occur.

Signature: _____ Date: _____