amazingsmiles
family & cosmetic dentistry

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you and we are glad you are here!

ABOUT PATIENT

Today's Date: _____ E-Mail Address: _____

Patient's Name: _____ Date of Birth: ____-____-____
(Last, First MI)
Age: _____
Preferred Name: _____ Male:☐ Female:☐

Social Security Number: ____-____-____ Home Number: (____) ____-____

Home Address: _____ Work Number: (____) ____-____

City: _____State: _____Zip:_____ Cell Number: (____) ____-____

Marital Status: Single:☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐

Can we text appointment information to your cell phone? Y: ☐ N: ☐ Email? Y: ☐ N: ☐

Employer Name: _____ Occupation: _____

Employer Address: _____ How long employed there? _____

City: _____State: _____Zip:_____

How did you hear about us? (Include referral name, if applicable): _____

DENTAL HISTORY

Your current dental health is: Good: ☐ Fair: ☐ Poor: ☐ Do your gums ever bleed? Yes: ☐ No: ☐

Do you like the color of your teeth? Yes: ☐ No: ☐ Do you like the size and shape of your teeth? Yes: ☐ No: ☐

Are you afraid of needles? Yes: ☐ No: ☐ Do you feel like you have cavities at most check-ups? Yes: ☐ No: ☐

Do you have any dental fears? _____

How can we make your dental visit more comfortable? _____

What would you change about your smile if you could? _____

Why have you come to the dentist today? _____

How long since your last dental visit? _____ Name of previous dentist: _____

Why did you leave your last dentist?_____

What else would you like to tell us? _____

_____

---OVER---

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EMERGENCY CONTACT/SPOUSE INFORMATION

His/Her Name: _____ Employer: _____

Date of Birth: ____-____-____ SS#:____-____-____ Work #: (____) ____-____

Cell #: (____) ____-____

DENTAL INSURANCE INFORMATION

Name of Employee: _____ **Name of Employer:** _____

Patient's Relationship to the employee: _____ Insurance Co. Name: _____

Employee's ID#:_____ Address: _____

Employee's DOB: ____-____-____ Group#_____ Phone # for customer service: (____) ____-____