Welcome

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You

Date:____
Name: ______________________________________
I like to be called: ____________________________
Home Address : ______________________________
________________________Zip:_________________
Home Phone:_________________________________
Work Phone__________________________________
Cell Phone: __________________________________
Email:_______________________________________
Date of birth_________________________________
Social Security Number_________________________
Your employer:_________________________
Your occupation:_______________________
Marital status:
Single__ Married__ Divorced__ Widowed__
Spouse's name:________________________
Best place to call you:___________ When:________
In case of emergency, is there someone we can call?
Name: _____________________________________
Other Phone:________________________________
Home Phone:________________________________
Who can we thank for referring you?_____________

Insurance Information

Employee with insurance:_____________________
Date of Birth:_______________________________
Employee Social Security Number:______________
Employer:___________________________________
Insurance company:__________________________
Group number:______________________________
Phone number:______________________________

Dental History

Why have you come to the dentist today?__________________
____
Many patients consult us for a second opinion. Have you seen another dentist for your dental needs?
No___ Yes___ If yes, please explain:_______________________
____

How would you describe the condition of your teeth and gums?
Good____ Fair____ Poor_____
Are you currently in pain or discomfort with your teeth or gums?
No___ Yes____ If yes, please explain:_______________________
____
The date of your last dental visit:___________________________

Previous dentist's name:_________________________________
Have you ever had previous gum treatment? No_____ Yes_____
If you could change anything about the appearance of your smile, what would you like to do?______________________________
If you could easily and safely whiten your teeth, would you be Interested? Yes_____ No____
How often do you brush your teeth?_____________________
How often do you floss your teeth?______________________
Do your gums bleed when you brush? Yes____ No____
Do your gums bleed when you floss? Yes_______ No_________
Have you ever been treated for TMJ symptoms?_____________
No_______ Yes______ If yes, please explain:________________
____
Have you ever experienced pain in your jaw joint? No____ Yes____

Do you grind your teeth? Yes_____ No______

Promise Esthetic Family Dentistry
595 Chapel Hills Drive, Suite 105
Colorado Springs, CO 80920
719-528-5577
promisefamilydentistry.com

Medical History

Name of Personal Physician:_________________________
Phone number:____________________________________
Last visit with Physician:____________________________
Current health: Excellent____ Good___ Fair___ Poor____
Do you smoke or use chewing tobacco? No__ Yes__ If yes, how much per day?_______________________________
____
Are you currently taking prescription medications?
No___ Yes___ If yes, please list below:
Name of medication and purpose
____
____
____
Have you ever taken Phenfen? No___ Yes___
Have you had any serious medical problems within the past five years? No ___ Yes ___ If yes, please explain:_______
____
____
Have you ever had, or been treated for, any of the following diseases or medical problems?

Y N Heart Attack? Stroke
Y N Heart Murmur/Rheumatic Fever
Y N Hepatitis/Jaundice
Y N Epilepsy/Seizures/Fainting
Y N Cancer/Chemotherapy
Y N Emotional Problems
Y N High/Low Blood Pressure
Y N Drug/Alcohol Abuse
Y N Abnormal Bleeding
Y N Anemia
Y N Diabetes
Y N AIDS?HIV
Y N Kidney Problems
Y N Tuberculosis

Have you been treated for any other illnesses not listed above?
No___ Yes___ If yes, please explain:_____________________
____

Are you allergic to any medications?_______________________
____
____
Do you need to be pre-medicated before dental treatment?
No___Yes___ Don't' know___
Have you or are you receiving any drugs intravenously, such as Aredia or Zometa (bisphosphonate) drugs)? No____ Yes____

For Women:

Are you pregnant? No__ Yes__ If yes, how many months? ____
Do you plan on becoming pregnant in the near future and, if so, when?____

____
I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor and his staff to use any photos he may take for lecturing or for education purposes.

____
Signature

____
Date

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