NICK SMITH, D.D.S.

DATE_____

TO OUR NEW PATIENTS:
Welcome to our office. We appreciate your confidence in selecting us to care for your teeth. We will do our best to make your appointments as pleasant and convenient as possible. If at any time you have any questions regarding your treatment, appointments, or fees, please feel free to ask.

PATIENT'S NAME_____ BIRTHDATE_____

ADDRESS_____ APT/UNIT #_____

CITY_____ STATE____ ZIP_____ EMAIL _____

HOME PHONE #_____ CELL PHONE #_____

OCCUPATION_____

WHO REFERRED YOU?_____

EMPLOYED BY_____ WORK PHONE # _____

SPOUSE EMPLOYED BY_____ WORK PHONE # _____

DO YOU HAVE A PARTICULAR DENTAL PROBLEMS OR DISCOMFORT? _____

PLEASE DESCRIBE_____

_____

WHEN WAS YOUR LAST DENTAL VISIT? WERE DENTAL X-RAYS TAKEN ?

_____

DO YOU FEEL THE QUALITY OF YOUR DENTAL CARE IN THE PAST HAS BEEN
(A) EXCELLENT (B) GOOD C) FAIR D) POOR

	YES	NO
Do you have any pain in any part of your mouth or teeth while biting or chewing?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do your gums bleed while chewing, brushing, flossing or at any other time?	☐	☐
Do your gums hurt or are they swollen?	☐	☐
Does food catch between your teeth?	☐	☐
Have you ever had any gum or bone treatment by a periodontist?	☐	☐
Have you ever had your bite adjusted or your teeth ground?	☐	☐
Have you ever worn braces or orthodontics?	☐	☐
Do you clinch or grind your teeth while awake or asleep?	☐	☐
Does your jaw or jaw joint make noises, pop, or hurt when you open or close?	☐	☐
Are you pleased with the appearance of your teeth?	☐	☐
Is there anything about dental treatment that bothers you?	☐	☐

(PLEASE CONTINUE ON REVERSE SIDE)