Steve Mays, D.D.S.

Phone: (615) 452-1225

We would like to get to know you better!

DATE_______________

NAME_______________

SOCIAL SECURITY#_______________

DATE OF BIRTH_______________

ADDRESS_______________

____
CITY STATE ZIP CODE

EMAIL ADDRESS_______________

PHONE_______________ CELL_______________

OCCUPATION_______________

EMPLOYER_______________

ADDRESS_______________

____
CITY STATE ZIP CODE

WORK PHONE_______________

MARITAL STATUS_______________

SPOUSE'S NAME_______________

SOCIAL SECURITY#_______________

DATE OF BIRTH_______________

SPOUSE'S OCCUPATION_______________

EMPLOYER_______________

ADDRESS_______________

_______________ PHONE_______________

Do you have a dental benefit plan?_______________

If yes, carrier_______________

Person responsible for account_______________

WHOM MAY WE THANK FOR REFERRING YOU?

____

MEDICAL HISTORY

	YES	NO
Do you have any general health problems?	☐	☐

If so, please specify _______________

Are you currently under a physicians care?	☐	☐

Reason _______________

Name and Address of physician

____

Are you currently taking any drugs or medication?	☐	☐

If so, what _______________

____

Are you pregnant?	☐	☐

Have you had any of the following diseases or medical problems?

Y	N	Heart Attack/Stroke	Y	N	Shingles
Y	N	Heart Murmur/Rheumatic Fever	Y	N	Kidney problems
Y	N	Heart Surgery/Pacemaker	Y	N	Sinus problems
Y	N	Chronic Hepatitis	Y	N	Fever Blisters
Y	N	Anemia	Y	N	Psychiatric problems
Y	N	High/Low Blood Pressure	Y	N	Diabetes
Y	N	Epilepsy/Seizures/Fainting Spells	Y	N	Tuberculosis (TB)
Y	N	Drug/Alcohol Abuse	Y	N	Artificial Joint
Y	N	Hemophilia/Abnormal Bleeding	Y	N	Stent
Y	N	Mitral Valve Prolapse	Y	N	Shunt
Y	N	Cancer/Chemotherapy	Y	N	Thyroid problem
Y	N	HIV + AIDS	Y	N	Radiation Treatment
Y	N	Asthma	Y	N	Emphysema

____

____

Any other serious medical conditions

Have you experienced any that are not listed above? ☐Yes ☐N

If yes, please list: _______________

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Codeine

Are you allergic to any other drugs? ☐ Yes ☐ No

If yes, please list: _______________

____
Signature **Date**

OVER PLEASE →

DENTAL HISTORY

	YES	NO
1. Are Your teeth sensitive to:		
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
2. Does food constantly get stuck between certain teeth in your mouth?	☐	☐
3. Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
4. Have you ever had any teeth removed?	☐	☐
5. Do your gums bleed when brushing?	☐	☐
6. Have you been instructed regarding proper home care?	☐	☐
7. Do you have an unpleasant taste or odor in your mouth?	☐	☐
8. Do you smoke?	☐	☐
9. Do you frequently snack between meals on sweets or soft drinks?	☐	☐

10. How often do you brush your teeth? ______________________

11. How often do you use floss? ______________

12. Do you want to learn to control dental disease and retain your teeth?	☐	☐
13. Has the fear of discomfort kept you from regular dental visits?	☐	☐

14. When was your last dental appointment? ______________________

15. What did you have done? ______________

16. How long since your last *thorough* examination with *full mouth x-rays*? ______________

17. What prompted you to seek dental care at this time? ______________________

REMARKS

____

____

____

SMILE EVALUATION

How do you feel about your smile? Please rate your smile from 1 to 10 (1= I hate my smile, 10=awesome) ______________

Would you like to have white teeth? Yes ☐ No ☐

Do you have any spaces between your teeth that bother you? Yes ☐ No ☐

Are your teeth crooked or crowded enough to concern you? Yes ☐ No ☐

Is there anything about the shape of your teeth that you don't like? Yes ☐ No ☐

If you had a magic wand, which of the improvements below would you change about your smile?

- ☐ Lighten Teeth
- ☐ Straighten
- ☐ Lighten single tooth
- ☐ Shorten
- ☐ Close spaces between teeth
- ☐ Repair uneven edges
- ☐ Eliminate dark or stained fillings
- ☐ Rebuild fracture(s)
- ☐ Lengthen
- ☐ Reduce gums showing
- ☐ Eliminate crowding

Please add anything you feel is important:

____

____

____

____

____

____

____

____