

Today's date: _____

WELCOME.....

We are happy to have you join our great family of patients and friends. 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 we can provide the best care possible for you. Thank you!

ABOUT YOU

Name: _____ Female Male

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Birth Date: ____/____/____

SSN: _____ Driver License No.: _____

E-mail Address: _____

Employer: _____

Position: _____

Business Address: _____

Marital Status: Single Married Widowed

Name of Spouse: _____

Spouse's Birth Date: ____/____/____ Spouse's SSN: _____

Spouse's Employer: _____

Children's Names & Ages: _____

How do you enjoy spending your free time? _____

Whom may we thank for referring you? _____

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Phone: _____

Address: _____

INSURANCE INFORMATION

Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please bring your dental card with you to your appointment.

Mike Hinkle, DDS
1720 S. Utica Ave.
Tulsa, OK 74104

918-712-0000
www.tulsa-smiles.com

DENTAL HISTORY

What prompted you to call our office? _____

When was your last dental visit? _____

Previous dentist's name: _____

Did you have regular check-ups as a child? Yes No

As a child, did you have a lot, average or very little tooth decay? _____

Describe the condition of your teeth: Excellent Good Fair Poor

Describe the condition of your gums: Excellent Good Fair Poor

Have you ever been told you have bad breath? Yes No

Do you currently have any oral pain or discomfort? Yes No

If yes, please explain: _____

Have you ever had any particularly good or bad experience with dentistry?

Do you have any dental anxieties? Yes No

If yes, please explain: _____

Has a dental team ever helped you set up a treatment plan? Yes No

If you could wave a magic wand and change anything about the appearance of your smile, what would it be? _____

Would you like to easily and safely whiten your teeth? Yes No

As you come into a new dental practice, what are your expectations, concerns and/or other priorities? _____

TELL US ABOUT YOUR HABITS

Do you: Clench your teeth during the day? Yes No

Grind your teeth at night? Yes No

Bite your lips or cheeks regularly? Yes No

Sleep with your mouth open? Yes No

Chew tobacco or smoke? Yes No

Consume alcohol daily? Yes No

TELL US ABOUT YOUR MOUTH

Do you have areas in your mouth that are sensitive to heat, cold or pressure? If so, where? _____

Do you have areas that are bleeding? If so, where? _____

SURVEY

Please rate the following on a scale from 1 to 5 (1 being not important and 5 being very important):

How important is your dental health to you? ____

How important is your dental health on your total body health? ____

How important is it for you to have your teeth cleaned at least every 6 months? ____

How does a person's breath influence your opinion of that person? ____

How important do you think the attractiveness of a person's smile is on the over all first impression they make? ____

How important is the whiteness or brightness of your teeth? ____

What is the most important thing to you about your smile and dental health?

TELL US ABOUT YOUR PERIODONTAL HEALTH

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? Yes No Floss? Yes No

Have you ever been treated for periodontal disease? Yes No

If so, did you have: Scaling and Root Planning? Yes No Surgery? Yes No

Do you suspect that you have mouth odor? Yes No

Have you noticed any loosening or mobility of your teeth? Yes No

Do you suffer from pain and/or swelling of your gums, or have any pus around your gums? Yes No

TELL US ABOUT ANY PROBLEMS WITH YOUR JAW, EARS AND EYES

Have you ever been treated for TMJ? Yes No

Have you ever experienced clicking in either jaw joint? Yes No

Have you ever experienced pain in either jaw joint? Yes No

Does your jaw joint ever lock? Yes No

Do you have difficulty sleeping? Yes No

Chronic neck or shoulder pain? Yes No

Do you get tension headaches? Yes No Migraine headaches? Yes No

Do you get headaches on the right or left temple areas? Yes No

Do you get headaches on the back of your head? Yes No

Have your teeth or jaws been sore upon wakening? Yes No

Is there a family history of jaw joint (TMJ) problems or headaches? Yes No

Do you ever have ear pain? Yes No

Do you ever have itchiness or stuffiness in either ear? Yes No

Do you ever hear ringing, buzzing or hissing sounds in either ear? Yes No

Do you suffer from hearing loss? Yes No

Do you get pain in, around or behind either eye? Yes No

Are there times when your eyesight blurs? Yes No

Do you wear contacts or glasses? Yes No

Do you snore? Yes No

Do you wake feeling rested? Yes No

TELL US ABOUT YOUR MEDICAL HISTORY

Name of personal physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Approximate date of last visit: _____

Current health condition: Excellent Good Fair Poor

Have you had any serious health problems in the last five years? Yes No If yes, please explain: _____

(For women) Are you currently pregnant? Yes No If yes, how many months? _____

Do you take any vitamin or herbal supplements? Yes No If yes, what kind: _____

Are you currently taking: A beta-blocker? Yes No A monoamine oxidase inhibitor (MAOI) Yes No

Please list any other prescription medications and their purpose: _____

When was your last blood pressure reading? _____ What was it? _____

