Dr. Michael W. Davis - SMILES OF SANTA FE

" Care Unlike Any Other!"

Welcome to SMILES OF SANTA FE. Would you be kind enough to answer the following questions? Please let us know if we could offer you water or fruit juice? Thank you so much for being our guest.

Patient:

Name Last ______________________ First ______________ Middle ______

Sex: M F DOB ____________________ SS# ______________________________

Mailing Address Street __________________________ Apt # ______ P.O. Box ______________

City ____________________ State ______________ Zip ______________________

Home Phone (___) ________________ Work Phone (___) ________________

Email Address ____________________________________ Cell Phone (___) ______________

Employer ____________________________ Occupation ______________________________

How Did You Hear About Our Office? ______________________________

Reason For This Visit ____

Spouse / Partner – Parent / Guardian (if minor)

Name ____ DOB ______________

Employer ______________________ Occupation ______________________________

Work Phone ____________________ Social Security Number ______________________

Medical History:

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
Women are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

For What? ____

What MEDICATIONS are you currently taking? ______________________________

____

HAVE YOU REACTED ADVERSELY TO Local Anesthetic/Novacaine

Is there any other Medical information that you feel that I should know about? ______________________________

____

FAMILY PHYSICIAN ______________________ **PHONE NO.** ______________

PLEASE CHECK IF YOU HAVE HAD, OR PRESENTLY HAVE:

- ☐ AIDS/HIV
- ☐ Allergic to Acrylic
- ☐ Allergic to Aspirin
- ☐ Allergic to Codiene
- ☐ Allergic to Latex Rubber
- ☐ Allergic to Metal
- ☐ Allergic to other Meds
- ☐ Allergic to Penicillin
- ☐ Angina / Chest Pain
- ☐ Artificial Heart Valve
- ☐ Cancer
- ☐ Chemotherapy (Cancer)
- ☐ Congential Heart Disorder
- ☐ Diabetes
- ☐ Has Taken Phen - Fen
- ☐ Heart Attack / Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Heart Trouble / Disease
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (Serum)
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Acid Relfux/Heart Burn
- ☐ Irregular Heart Beat
- ☐ Joint Replacement / Implant
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Radiation Therapy
- ☐ Rheumatic Fever Scarlet Fever
- ☐ Bone Building Meds Boniva /Fosamax/Etc.

Do you require antibiotic for dental treatment? YES NO

Do You Have Dental Insurance? YES ☐ NO ☐ We will need a copy of your insurance card.

Although we do not accept insurance assignment, as a courtesy we will file your claims for you. It is important that we have the right insurance information so that you receive your reimbursement as quickly as possible.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date?		
Last FULL MOUTH X-RAYS, Date? (18 small Films or Panoramic)		
Are you having Dental Problems now?	☐	☐
WHAT?		
Do you wear Partials?	☐	☐
Are you UNHAPPY with your Partials?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are you concerned about METAL fillings?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Name of Previous Dentist:		
City: State:		
May we request previous x-rays?		
Please RANK the following in the order in which it would KEEP YOU FROM having dental treatment.		
FEAR of pain # LACK of concern #		
COST of treatment # MISSING work time #		

CONSENT FOR USE OF PHOTOGRAPHS

Dr. Davis often uses photographs of successful cases to explain and display to other dentists or other interested parties. We appreciate your willingness to allow us use of your photographs, because pictures are really the only way for someone to be able to imagine what improvements can be made. In case of a display or advertising need, we will ask you again for your permission - this consent is merely for internal and dental educational purposes.
Thank you!

Date ____________ Print Name ____________

Signature ____________

CONSENT FOR DISPLAY AND MODELING PHOTOGRAPHS

I hereby give my consent to Dr. Davis for the use of any and all photographs for his use in display or advertising purposes. Any exceptions will be noted below.

Date ____________ Print Name ____________

Signature ____________

Authorization:

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature of Patient or Parent of Minor ____________________________

Date ____________