Welcome To

We are happy you're here. Please, take a moment to aid us in providing the best treatment of your dental needs by completing this welcome questionnaire.

Patient Information

First Name_____ Last Name_____ M.I._____
Address_____
City_____ State_____ Zip_____
Best Phone Number_____ Work Phone Number_____
Date of Birth_____ Age_____ Sex_____ Marital Status_____
Social Security Number _____ Driver's License Number_____
Email Address _____

Responsible Party (If someone other than the patient)

First Name_____ Last Name_____ M.I._____
Address_____
City_____ State_____ Zip_____
Best Phone Number_____ Work Phone Number_____
Date of Birth_____ Social Security Number _____
Driver's License Number_____ Email Address _____

Primary Insurance Information

Name of Insured _____ Relationship to Patient: Self Dependent Spouse
Insured Social Security Number or Identification number _____
Insured DOB_____ Insured Employer _____
Insurance Company _____

Dental History

Are you currently in discomfort requiring our immediate attention? YES NO
If Yes, please explain_____
Have you had regular dental checkups? YES NO
When was your last visit? _____What was done then? _____
Do your gums bleed when brushing or flossing? YES NO
Are you apprehensive about receiving dental treatment? YES NO
Have there been any complications during previous dental treatment? YES NO
If yes, please explain_____
Do you have frequent headaches? YES NO
Do you clench or grind your teeth during wake or sleep? YES NO
Do you wear a night guard? YES NO
Have you ever been diagnosed with Sleep apnea? YES NO
Do you snore? YES NO
Do you wear dentures or partials? YES NO
Have you ever had Botox treatment in the past? YES NO
If yes, was it for cosmetic purposes or TMJ issues? YES NO
Are you interested in having Botox Treatments? YES NO
If there is anything you would like to change about your smile, what would it be?
Crowding Gaps Bite Rotations Color Size Other
Please Explain _____