Please Help Us Understand You!

Patient Name: _____ **Date:** _____

Our office is different in that we give our patients our full attention.
We schedule one patient at a time, find out what is important to them and deliver what we promise.
Please answer the following so we can better understand your needs.

How can we help you?

Are you looking for a new dental home? **YES** **NO**

Do you plan on returning to your old dentist after your treatment is complete? **YES** **NO**

I am interested in:

Same Day New Smile™	Smile Makeover	Metal-free Implants
Golden Ratio Rejuvenation™ (Non-surgical Facelift)	TMJD Treatment	Sedation Dentistry
Stem Cell Therapy	Filling upgrade	Laser Therapy

What is your time frame for the above?
_____

The first visit is designed to answer your questions as well as to allow you to see if we are the right dentist for you. If you feel we are not the best dentist for you, we will be happy to refer you to who we know is a good match for you. If you feel we can help you, we will take records, do a thorough examination, and give you specific options for your dental treatment.

Please begin thinking about the following

How important are the following concepts:
DENTAL HEALTH, PREVENTION, DENTAL COSMETICS, and **FACIAL COSMETICS**?

We will be discussing this with you shortly.

Thank you!

Shawn Keller, DDS, and the Team at Smiles by Design

SHAWN KELLER
SMILES BY DESIGN

Patient Name _____ Date of Birth_____

Address_____ City_____

Zip_____ Home Phone # _____ Cell Phone #_____

Email _____

Who May We Thank for Referring You to Us _____

Employer _____ Work Phone_____

Primary Physician _____ Phone # _____Date of Last _____

Emergency Contact _____ Relationship to Patient_____

Emergency Contact Phone #
_____

List any current medications: Please include any blood thinning medications or
aspirin?_____

Are you allergic to any medications or other substances? **YES** **NO**
_____

Have you taken or currently taking medications for osteoporosis Known as bisphosphonates for Fosamax, Actonel or Boniva?
YES **NO** Medication:_____

Check if you have: seen an Orthodontist- had your bite adjusted, had any bite related treatment- TMJ Joint Surgery

Check if you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor or Massage Therapist

Do you snore, use a CPAP or have had a sleep study? **YES** **NO**

Have you ever had radiation to the head and/or neck? **YES** **NO**

Please list your current weight: _____ Please list your current height: _____ft _____in

Do you use Tobacco Products (smoking/vaping, etc.)? **YES** **NO** History of drug/substance abuse? **YES** **NO**

Please answer Yes or No to the following:									
AIDS/HIV	**YES**	**NO**	Heart Murmur	**YES**	**NO**	Tuberculosis	**YES**	**NO**
ANEMIA	**YES**	**NO**	Heart Problems	**YES**	**NO**	Jaw Popping	**YES**	**NO**
Arthritis or Rheumatism	**YES**	**NO**	Hepatitis Type _____	**YES**	**NO**	Ulcer	**YES**	**NO**
Artificial Heart Valve	**YES**	**NO**	High Blood Pressure	**YES**	**NO**	Sleep Apnea	**YES**	**NO**
Artificial Joint	**YES**	**NO**	Kidney Disease	**YES**	**NO**	Headaches	**YES**	**NO**
Asthma	**YES**	**NO**	Liver Disease	**YES**	**NO**	Jaw Pain	**YES**	**NO**
Abnormal Bleeding w/ extractions/surgery	**YES**	**NO**	Mitral Valve Prolapse	**YES**	**NO**	Tumor/Growth head/neck	**YES**	**NO**
Blood Disease	**YES**	**NO**	Nervous Problems	**YES**	**NO**	Limited Opening	**YES**	**NO**
Cancer	**YES**	**NO**	Pacemaker	**YES**	**NO**	Congested Ears	**YES**	**NO**
Chemotherapy	**YES**	**NO**	Psychiatric Care	**YES**	**NO**	Ringing Ears	**YES**	**NO**
Circulatory Problems	**YES**	**NO**	Radiation Treatment	**YES**	**NO**	Posture Problems	**YES**	**NO**
Cortisone Treatment	**YES**	**NO**	Scarlet Fever	**YES**	**NO**	Clenching	**YES**	**NO**
Cough, persistent	**YES**	**NO**	Sinus Trouble	**YES**	**NO**	Grinding	**YES**	**NO**
DIABETES	**YES**	**NO**	Stroke	**YES**	**NO**	Facial Pain	**YES**	**NO**
Epilepsy	**YES**	**NO**	Swollen Feet or Ankles	**YES**	**NO**	Neck Ache	**YES**	**NO**
Fainting or Dizziness	**YES**	**NO**	Swollen Neck Glands	**YES**	**NO**	Bell’s Palsy	**YES**	**NO**
Glaucoma	**YES**	**NO**	Thyroid Problems	**YES**	**NO**	Other	**YES**	**NO**
Heart Lesions	**YES**	**NO**	Tonsilitis	**YES**	**NO**	Other	**YES**	**NO**