



Douglas Peak, D.D.S.
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719-599-0665 • www.allsmilesdentalgroup.com

Date \_\_\_\_\_

1. Patient's Name Last First Middle Driver's License # \_\_\_\_\_

2. Address Street City State Zip \_\_\_\_\_

3. Home Phone Birthdate Social Security # \_\_\_\_\_

4. E-Mail Address Cell Phone Work Phone \_\_\_\_\_

5. Person Responsible for Payment Last First Middle \_\_\_\_\_

6. Address Street City State Zip \_\_\_\_\_

7. Relationship to Patient \_\_\_\_\_ (if minor, list parent's names:)

8. Social Security # \_\_\_\_\_

9. Birthdate \_\_\_\_\_

10. Driver's License # \_\_\_\_\_

11. Home Phone \_\_\_\_\_

12. Employer \_\_\_\_\_

13. Work Phone \_\_\_\_\_

14. Patient's Spouse Name Last First Middle \_\_\_\_\_

15. Spouse's Employer \_\_\_\_\_

16. Occupation \_\_\_\_\_

17. Work Phone \_\_\_\_\_

DENTAL INSURANCE INFORMATION (need copy of card)

18. Insured's Name (employee) \_\_\_\_\_

19. Insured's Birthdate \_\_\_\_\_

20. Insured's Address (if different from above) \_\_\_\_\_

21. Insured's Social Security # \_\_\_\_\_

22. Insured's Employer \_\_\_\_\_

23. Insurance Co. Name Group Name \_\_\_\_\_

24. Insurance Address \_\_\_\_\_

EMERGENCY INFORMATION

25. Local Friend or Relative not living with you \_\_\_\_\_

26. Complete Address \_\_\_\_\_

27. Phone No. \_\_\_\_\_

GETTING TO KNOW YOU

28. Why did you select our office? \_\_\_\_\_

29. Whom may we thank for referring you? \_\_\_\_\_

30. Is another member of your family or relative a patient in our practice? \_\_\_\_\_

31. When was your last dental visit? \_\_\_\_\_

32. When was the last time you had complete dental X-rays taken? Dentist: \_\_\_\_\_

33. Have you ever had any teeth removed? \_\_\_\_\_

How long have these teeth been missing? \_\_\_\_\_
Have these teeth been replaced? \_\_\_\_\_

How? [ ] Bridge [ ] Partial [ ] Denture [ ] Implants

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems it. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE

**MEDICAL HISTORY**

1. Have you been under the care of a medical doctor during the past two years?  Yes  No  
If yes, for what reason? \_\_\_\_\_

2. Are you having dental problems at this time?  Yes  No

3. Do your gums bleed at any time?  Yes  No

4. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?  Yes  No  
If yes, please list. \_\_\_\_\_

5. Have you ever had excessive bleeding requiring special treatment?  Yes  No

6. Check any of the following which you have had or have at present:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Ulcers                          | <input type="checkbox"/> HIV Positive (AIDS)          |
| <input type="checkbox"/> Tuberculosis (TB)       | <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> Hepatitis A (Infectious)     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hepatitis B (Serum)             | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Heart Murmur/Mitral Valve    |
| <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Bruise Easily                |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Thyroid Disease                 | <input type="checkbox"/> Drug Addiction               |
| <input type="checkbox"/> Heart Pacemaker         | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Hemophilia                   |
| <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Artificial Joint        | <input type="checkbox"/> Cortisone Medication            | <input type="checkbox"/> Epilepsy or Seizures         |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Nervousness                  |
| <input type="checkbox"/> Kidney Trouble          | <input type="checkbox"/> Pain in Jaw Joints              | <input type="checkbox"/> Psychiatric Treatment        |

7. Do you have any disease, condition or problem not listed? If so, please list .....  Yes  No

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. List all medications you are taking at this time. \_\_\_\_\_

9. Are you a smoker?.....  Yes  No

10. Do you use or have you ever used recreational drugs?.....  Yes  No

11. Do you ever wake up from sleep short of breath? Do you snore?.....  Yes  No

12. Do you clench or grind your teeth? .....  Yes  No

13. Has your medication doctor ever said you have cancer or a tumor?.....  Yes  No

14. Women: Are you pregnant  Yes  No If yes, what month are you due? \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can make you as comfortable as possible.

1. Please rate, in order of value, what is most important to you in dental care: (The most important will be #1)

\_\_\_ Preventative Care

\_\_\_ Only what is necessary at the time: cost is important

\_\_\_ Comprehensive, quality care, best looking results

\_\_\_ Other \_\_\_\_\_

2. Please rate, as in #1, what is most important to you in your relationship with a dentist.

\_\_\_ Show me what he/she is doing or planning to do so I can clearly see what is happening

\_\_\_ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment

\_\_\_ Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

1    2    3    4    5    6    7    8    9    10

4. Are you concerned about: (please circle yes or no)

Replacing missing teeth                      Yes    No

Eliminating any cavities                      Yes    No

Gum disease                                      Yes    No

Bad breath                                        Yes    No

Snoring at night                                Yes    No

Color of your teeth                            Yes    No

Appearance of your smile                   Yes    No

5. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

1    2    3    4    5    6    7    8    9    10

6. When you review your treatment plan with you, would you like to know (please check one):

\_\_\_ The big picture of what needs to be done

\_\_\_ All the treatment details along the way

7. Why did you leave your last dentist? \_\_\_\_\_

\_\_\_\_\_