Designing Smiles by Laser
Ruben Armienta, DDS

Patient Information

Today's date_____
First Name_____ Middle Initial_____ Last Name_____
I prefer to be called (nickname, etc.)_____ ◯ Male ◯Female
Address_____ City_____ State____ ZIP_____
Date of birth_____ Social Security #_____
Home phone_____ Work phone_____ Cell phone_____
Primary contact number (please check one) ◯ Home ◯Work ◯Cell Best time to call_____
Fax (___) _____ E-mail _____ Driver's License #_____
Employer_____ Occupation_____
Spouse's Name_____Spouse's employer_____
Whom may we thank for referring you? _____

Dental History

My main dental concern is _____
Are you currently in pain ? ◯ YES ◯ NO
If so, please describe: _____
Do you have any dental problems now? ◯YES ◯NO
If so, please describe: _____
Have you ever had trouble with previous dental treatment? ◯YES ◯NO
If so, please describe:_____
Level of anxiety about seeing the dentist (least) 1 2 3 4 5 (most)

Date of last dental exam_____ _____
City_____ _____
Why are you changing dentist?_____

How often do you have dental examinations? _____How often do you brush your teeth? _____
How often do you floss? _____ What type of bristles do you use? ◯ Hard ◯ Medium ◯ Soft
What other dental aids do you use? (Electric toothbrush, toothpick, etc.)_____

OFFICE USE ONLY

*****RECALL PATIENTS ONLY*****

I certify that I have reviewed the documents medical history and list of medications, and I have indicated any changes. I acknowledge that my questions, if any, about any items listed above have been answered to my satisfaction .I will not hold the dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient/guardian signature:_____

Date:_____ Patient/guardian signature:_____

Date: _____ Patient/guardian signature: _____

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