

SmileArkansas

C. Lee Wyant, D.D.S.

Date _____

How did you first find out about our office? (circle one)

personal referral _____ location advertisement yellow pages internet other
name

Patient Information

Patient's Name _____
last first middle

Address _____
street city state zip

Phone _____ Social Sec. # _____
home work cell

Birthdate _____ E-mail _____

Employer _____ Dental Insurance _____

Responsible Party Information

Same as patient

Name _____
last first middle

Address _____
street city state zip

Phone _____ Social Sec. # _____
home work cell

Birthdate _____ E-mail _____ Relation to patient _____

Medical History

Have you ever had any of the following problems? Please circle all that apply.

Y	N	Heart Disease	Y	N	Asthma	Y	N	Seizure / epilepsy
Y	N	High / low blood pressure	Y	N	Hayfever/allergies	Y	N	Arthritis
Y	N	Heart murmur	Y	N	Sinus problems	Y	N	Ulcers
Y	N	Mitral valve prolapse	Y	N	Allergies to anesthetic	Y	N	Tonsilitis
Y	N	Rheumatic fever	Y	N	HIV / AIDS	Y	N	Cancer / radiation or chemotherapy
Y	N	Stroke	Y	N	Hip or knee replacement	Y	N	Psychiatric care
Y	N	Anemia	Y	N	Kidney or bladder disease	Y	N	Drug / alcohol addiction
Y	N	Abnormal bleeding	Y	N	Gall bladder disease	Y	N	Eye disorder
Y	N	Diabetes	Y	N	Thyroid disease	Y	N	Sexually transmitted disease
Y	N	Tuberculosis	Y	N	Hepatitis / liver disease	Y	N	Current pregnancy
			Y	N	Dry Mouth			

Are you being treated by a physician? Y N If yes, for what? _____

Physician's name _____ Phone _____

List all current medications _____

cont'd Medical History

Are you allergic to the following:

Y N Penicillin

Y N Aspirin

Y N Anesthetic

Y N Erythromycin

Y N Codeine

Y N Latex

List any other allergies _____

Is there anything else about your medical history you feel we should know? _____

Emergency Contact: _____
name relation phone

Dental Health

Is there anything you feel we should know about any past dental treatment? _____

Is there anything your previous dental office did that you want us to do? _____

Is there anything you didn't like? _____

To make our patients comfortable we offer several amenities. Circle all that you would like.

nitrous oxide (laughing gas) music (type of music or artists) _____

neck pillow blanket lip balm prescription medication

Smile Analysis

Are you unhappy with the overall appearance of your teeth, your smile? YES NO

Do you consider your teeth discolored, yellow or dark? YES NO

Would you like your teeth to be whiter? YES NO

Do you have any existing dental work you find unattractive? YES NO

If possible, what changes would you make to your smile? _____

The above information is correct to the best of my knowledge and I authorize the doctor and staff to provide dental services including photographic documentation for scientific and educational purposes. I assume responsibility for fees associated with all services provided.

Signature (Parent's signature if minor) _____