

# Welcome to Diem Do, DDS Smile In Style

This confidential information will help us prepare for your visit.

NAME \_\_\_\_\_

I prefer to be addressed as \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Single Married Divorced Widowed Separated

Cell # \_\_\_\_\_ Work # \_\_\_\_\_

E-Mail \_\_\_\_\_

Employer \_\_\_\_\_

## How would you prefer to receive appointment confirmations?

**Text**                      **E-Mail**                      **Cell phone**

Who may we thank for referring you to our office?

\_\_\_\_\_

Family members seen as patients here..

## Account Information

- Cash, Visa or personal check at time of service
- I have Dental Insurance to cover a portion of my fees

Name on Account:    **Self**        **Spouse**        **Other**

## Emergency Contact Information:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

## What prompted you to schedule this dental appointment?

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## Please check what applies to you

- I currently have no pain or sensitivity.
- I currently have pain or sensitivity.
- My mouth is very uncomfortable.
- My mouth is moderately comfortable.
- My mouth is uncomfortable.
- I think the appearance of my smile is excellent.
- I am interested in whiter teeth.
- I am curious about changing my smile.
- I am satisfied with the appearance of my teeth.
- I am aware of current dental treatment that I need.
- I am not aware that I need any dental treatment.
- I think my present state of dental health is excellent.
- I think my present state of dental health is good.
- I think my present state of dental health is poor.

## Concerns I see in regards to my dental health...

If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time.

\_\_\_\_\_ I see no obstacles

\_\_\_\_\_ Time away from work or other obligations

\_\_\_\_\_ Fear of pain, surgery, or injections

\_\_\_\_\_ Fear because of past dental experiences

\_\_\_\_\_ The cost of treatment

Other \_\_\_\_\_

