



Shane Matt, D.D.S
Authentic SMILES
Austin's Contemporary Cosmetic Dentistry Studio

New Patient Intake Form

Reset Form

Print Form

Submit Form

General Information

Name: _____ I prefer to be called: _____ Male Female
Social Security#: _____ Birth date: _____ Marital Status: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
How would you prefer to be contacted? _____
How did you hear about our office? _____
Employer: _____ Occupation: _____
Whom may we contact in the case of an emergency? _____ Phone: _____

Dental Insurance

Insurance Company: _____ Phone #: _____
Insurance Company Address: _____
City: _____ State: _____ Zip: _____
Are you the policy holder? Yes No If no, what is your relation to the policy holder? _____
Policy holder's name: _____ Birthdate: _____
Social Security #: _____ Employer: _____
Plan ID#: _____ Group/Plan #: _____
Do you have secondary insurance? YES NO
If yes, please let our administrative team know so that we may gather the necessary information.

I authorize Authentic Smiles to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize that payment be made directly to Authentic Smiles for services rendered. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all the information on this sheet and have verified the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature/Parent if minor

Date

Medical Information

Your current health: GOOD FAIR POOR

Current Physician: _____

Please list any medications that you are currently taking: _____

Women:

Are you pregnant? YES NO Due date: _____

Are you nursing? YES NO

Do you have or having ever been treated for any of the following diseases or conditions?

(select all those that apply)

| | |
|--------------------------------|------------------------|
| Abnormal Bleeding | Hepatitis |
| Alcohol/Drug Abuse | Herpes/Fever Blisters |
| Anemia | High Blood Pressure |
| Arthritis | HIV/AIDS |
| Artificial joints/bones/valves | Kidney Problems |
| Asthma | Liver Disease |
| Blood Transfusion | Low Blood Pressure |
| Cancer | Mitral Valve Prolapse |
| Congenital Heart Defect | Pacemaker |
| Diabetes | Psychiatric problems |
| Difficulty Breathing | Radiation treatment |
| Emphysema | Rheumatic Fever |
| Epilepsy | Scarlet Fever |
| Fainting spells | Seizures |
| Frequent Headaches | Shingles |
| Glaucoma | Sinus Trouble |
| Gum Disease | Stroke |
| Hay Fever | Thyroid Problems |
| Heart Attack | Tuberculosis (TB) |
| Heart Murmur | Ulcers |
| Heart Surgery | Venereal Disease (STD) |
| Hemophilia | |

Do you smoke or chew tobacco? YES NO

Do you need to be pre-medicated for Mitral Valve Prolapse, Heart Murmur, or any kind of joint/bone/valve replacement?

YES NO

Please select and of the following which you are allergic to:

| | | |
|---------|------------|--------------------|
| Aspirin | Codeine | Dental Anesthetics |
| Latex | Penicillin | Erythromycin |
| Codeine | Sulfa | Iodine |

Please list any other allergies: _____

Dental Information

Previous Dentist: _____

City/State: _____

Last Dental Visit: _____

Current Dental health: GOOD FAIR POOR

Are you happy with your smile? YES NO

If no, please tell us why: _____

Would you like for your teeth to be whiter?

Would you like for your teeth to be straighter?

Have you had orthodontic treatment?

Do you clench or grind your teeth?

Do you have pain in your jaw or face?

Do you have a bad odor/taste in your mouth?

Do your gums bleed when brushing/flossing?

Are your teeth sensitive to pressure?

Are your teeth sensitive to hot?

Are your teeth sensitive to cold?

Are your teeth sensitive to sweets?

Does food catch between your teeth?

Do you have silver or discolored fillings or un-natural looking crowns or bridges that you wished looked different? YES NO

If yes, please explain:

Please tell us about any other dental concerns that you may have or any information that you feel is important for us know:

Please tell us what you are looking for in a dental office, what is most important to you?
