

# Masterpiece Smiles

Michael B. Beeler, D.D.S.

The following information is for our records only and will be considered confidential.

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (M) \_\_\_\_\_ (W) \_\_\_\_\_  
Email address \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

## **Medical History**

Latex allergy      Y      N  
Diabetes            Y      N  
Hepatitis/HIV    Y      N  
Other allergies \_\_\_\_\_  
Heart condition   Y      N  
Epilepsy/Seizure Y      N  
High/Low blood pressure      Y      N  
Any other medical or health issues   Y      N  
If yes, list \_\_\_\_\_

## **Dental History**

When was your last dental visit? \_\_\_\_\_  
Are you having any dental sensitivity or pain at this time?   Y   N  
If yes, list \_\_\_\_\_

Other dental concerns \_\_\_\_\_

Would you like to improve the appearance of your smile?   Y   N  
If so, what? \_\_\_\_\_

**I certify that the information is true and correct to the best of my knowledge.**

(X) \_\_\_\_\_ Date \_\_\_\_\_  
Signature of patient or guardian, (if minor)

(X) \_\_\_\_\_ Date \_\_\_\_\_  
Michael B. Beeler, D.D.S.