

InStyleSmiles.com
R. Greg Carroll D.D.S.
Cosmetic and Family Dentistry

Thank you for choosing our practice for your dental needs. We are committed to providing reliable, gentle care to each of our patients and strive to make your visit as comfortable as possible.

Patient Information

Name _____ Preferred Name _____
Address _____ City _____ St _____ Zip _____
Birth date _____ SS# _____ Employer _____
Home # _____ Work # _____ Cell # _____
Email _____ Preferred Method of Contact _____
Marital Status _____ Referred By _____
Emergency Contact _____ Phone Number _____
Medical Doctor _____ Phone Number _____

Dental History

Previous Dentist _____ Date of Last Visit _____
Reason for Today's Visit _____

Please indicate if you have any of the following problems:

<input type="checkbox"/> Discomfort, Clicking, Popping of Jaw	<input type="checkbox"/> Lost/Broken Fillings	<input type="checkbox"/> Stained Teeth
<input type="checkbox"/> Red, Swollen, or Bleeding Gums	<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Locking Jaw
<input type="checkbox"/> Sensitive Tooth, Teeth, or Gums	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Bad Breath
<input type="checkbox"/> Blisters/ Sores	<input type="checkbox"/> Broken/ Chipped Tooth	

How many times a day do you Brush _____ Floss _____

