Patient Information

Name_____ Social Security _____

Address_____City_____State_____Zip Code_____

Home Phone_____Cell Phone_____E-Mail_____

Birthdate_____ Sex ____F ____ M

Whom may we thank for referring you?_____

Patient Employed by_____Occupation_____

Business Address_____ Business Phone_____

Family physician(s)_____Last physical_____

Physician's Address/Phone Number _____

In case of emergency, Contact person _____Phone Number_____

Authorization

Privacy Act
I acknowledge notification and receipt of the Notice of Privacy Practice.
I give consent to use or disclose protected health information to another family member in order to carry out treatment, payment and healthcare operations. (please list name(s)

Name	Relationship
_____	_____
_____	_____

I authorize use of my name to be printed in the newsletter either as "being welcomed as a new patient or being thanked for referring a patient",
I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature (Parent or Guardian if under 18 years of age) _____Date_____

FOR OFFICE USE ONLY

Health Update

Has there been any change in your general health in the past year? (allergies, new medications, vitamins)

YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____
YES NO Date_____ Describe:_____

Health Questionnaire

Name:_____Date:_____

Present Health Status: (Circle one) EXCELLENT GOOD FAIR POOR DON'T KNOW

YES NO Have you had a serious illness, operation or hospitalization during the past five years? If yes, please describe:
_____

YES NO Are you taking or have you recently taken any prescribed medication or inhalers? (please list medication & reason)
_____

YES NO Over the counter medication, natural or herbal preparations?_____

YES NO Have you ever taken Pondimin (Fendluramine), Phen-Fen (Phentermine) or Redux (Dexphenfluramine) for weight loss?
_____

YES NO Has your physician told you to take antibiotics prior to having any type of dental procedure? If so, why?
_____What do you take?_____

YES NO Are allergic to any medication, drugs, latex or iodine?_____

YES NO Have you ever had an adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)
_____

YES NO Have you ever had excessive bleeding that required special treatment?_____

YES NO Have you been diagnosed as having immunodeficiency, systemic Lupus, or Aids?_____

YES NO Is there a history of Diabetes in your family?_____

YES NO Are you required, due to health, to restrict your work or activity in any way?_____

YES NO Are you on a special or restricted diet of any kind?_____

YES NO Do you use any kind of tobacco? If so, how much:_____per day, week, month How long?_____

YES NO Do you have any history of substance abuse or do you currently use recreational drugs?
_____

What types of beverages do you drink throughout the day?_____

Check the following that applies to you:

___chest pain upon exertion
___shortness of breath
___high blood pressure
___low blood pressure
___heart valve prosthesis
___mitral valve prolapse
___congenital heart lesion
___rheumatic fever
___heart murmur
___damaged heart valve
___heart arrhythmia
___tachycardia
___heart surgery
___cardiac pacemaker
___cerebral vascular disease

___hepatitis or jaundice
___elevated cholesterol
___neurological disorders
___stroke
___headaches
___received blood transfusion
___impaired liver function
___kidney disease
___impaired kidney function
___esophygeal reflux
___hiatal hernia
___G.I. Ulcers
___anorexia or bulimia
___irritable bowel syndrome

___colitis
___diabetes
___Crohn's disease
___radiation therapy
___chemotherapy
___history of cancer
___migraines
___epilepsy
___seizures
___mental health problems
___joint replacement surgery
___arthritis
___connective tissue disorder

___sleep apnea
___asthma
___bronchitis
___emphysema
___sinus problems
___persistent cough
___tuberculosis
___glaucoma
___contact lenses
___severely impaired vision
___cold sores, fever blisters

Do you have any disease, problem or condition that is not listed above? If so, please explain:

_____

For women, check all that apply: _____I am pregnant _____I am nursing _____I am taking birth control pills

Dental History

Name:_____Date:_____

Are you presently satisfied with the condition of your mouth and teeth? (circle one)

VERY SATISFIED SATISFIED IT'S OK SOMEWHAT DISSATISFIED VERY DISSATISFIED

What level of dental health do you aspire to? (circle one)

EXCELLENT GOOD FAIR NOT IMPORTANT

How would you rate your smile at this time? (circle one)

1 2 3 4 5 6 7 8 9 10

Any dental fears or significant past dental experience?_____

YES NO Do you have any discomforts, sensitivity, pain or concerns related to your mouth? If yes, please describe:
_____

YES NO Are you currently aware of any infection in your mouth? If yes, please describe:
_____

YES NO Are you aware of any receding or bleeding gums?

YES NO Are you interested in replacing lost teeth?

YES NO Are any of your teeth tender when you chew hard foods?

YES NO Are there any areas where you are getting food stuck in your teeth?

YES NO Do you ever experience dry mouth?

Dental History (continued)

YES NO Would you like to discuss any of the following? (please check)

_____missing teeth
_____implants
_____veneers
_____old silver fillings
_____tooth colored fillings
_____color of teeth
_____drill-less dentistry
_____air abrasion (decay removal)
_____porcelain crowns
_____whitening your teeth
_____straightening teeth without braces

Check any of the following that describe you or makes dental treatment easier for you:

____I tolerate most dental care reasonably well.
____I tolerate injections in my mouth well.
____I am fearful of dental injections.
____I prefer to be medicated to relax, or sedated for treatment.
____I have a hard time sitting in the dental chair for more than an hour.
____I have difficulty keeping my mouth open wide.

Smile Assessment

Name:_____Date:_____

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or smile.	YES	NO
2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.	YES	NO
3. I am concerned about the position or angle of one or more my teeth.	YES	NO
4. I am concerned about the shape of one or more of my teeth.	YES	NO
5. In social situations, I am sometimes embarrassed by my teeth or my smile.	YES	NO
6. There are some things about my upper front teeth that I would like to change.	YES	NO
7. There are some things about my lower front teeth that I would like to change.	YES	NO
8. I have old fillings or previous dental treatment that is no longer satisfactory to me.	YES	NO
9. My bite is sometimes uncomfortable when chewing or biting.	YES	NO
10. I am interested in learning more about esthetic dentistry.	YES	NO
11. I have spaces or missing teeth that I am aware of.	YES	NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank You.

_____

_____

_____

_____

_____

_____