



My Best Smile

"Preserving Smiles for Generations"

Today's Date: _____ Reason for your Visit: _____

Whom may we thank for referring you? _____

Patient Name & Personal Information

Last: _____ First: _____ Middle _____ Nickname: _____

Birthdate: _____ Age: _____ S.S.#: _____ M F Marital Status: M S D

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Email: _____

Primary Dental Insurance Information

Insurance Co.: _____ Address: _____

Phone: _____ ID #: _____ Group #: _____

Primary Insured's Information

Name: _____ Relationship to Patient: _____

Employer: _____

Dental History

Date of Last Visit: _____ Date of Last Cleaning: _____

Date of Full Mouth X-Rays: _____

If other than a routine check-up, what was done at your last visit? _____

How often do you brush: _____ How often do you floss: _____

Have you ever used topical fluoride? Yes or NO

Have you ever had:	Yes	No	Have you ever had:	Yes	No
Sensitive to hot or cold			Orthodontic Treatment?		
Sensitive to sweets			Oral Surgery?		
Sensitive to biting or chewing			Periodontal treatment (gum disease)?		
Any mouth odors or bad tastes?			A bite plate or mouth guard?		
Do you frequently get cold sores, blisters or any other oral lesions?			Serious injury to the mouth or head?		
Do your gums bleed or hurt?			If so, please describe:		
Have you noticed any loose teeth or change in your bite?			Have you experienced:		
Does food tend to become caught in between your teeth?			Clicking or popping of the jaw		
Do you mouth breath while awake or asleep?			Pain in the joint, ear or side of face?		
Do you snore or have any sleeping disorders?			Difficulty in opening or closing the mouth, Head, neck or shoulder aches?		
Do you Smoke or chew tobacco or use other tobacco products?			An upsetting dental experience?		
Do you clench or grind your teeth while asleep or awake?			If so please describe:		
Are you satisfied with the appearance of your teeth?					
Would you like to keep all of your teeth all of your life?					
Do you feel nervous about having dental treatment?					
If so, what is your biggest concern?					

Is another member of your family or a relative a patient at our office?

Name: _____ Relationship: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Closest Relative NOT living with you

Name: _____ Relationship: _____ Phone: _____

Primary Care Provider

Physician's Name: _____ Phone Number: _____

Have you had any medical care within the past 2 years? Yes No

If so, please describe: _____

	Yes	No		Yes	No
Have you taken any medications or drugs in the last 2 years?			Have you been a patient in the hospital during the past 5 years?		
Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?			Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs?		
If yes, please list names and dosages:					
Have you taken prescription medications for weight loss (diet pills)? Please indicate if you have taken any of the following:			Are you aware of having an allergic (or adverse) reaction to any substance or medications? If yes, please specify:		
Fen-Phen			Are you pregnant or think you could be pregnant?		
Pondimin			If YES, how many months?		
Redux			Are you nursing?		
Other			Do you use birth control prescriptions?		
If YES to any of the above, did you have a medical exam for heart issues?			Have you lost or gained more than 10 pounds in the past year?		

Indicate with an X any of the following you presently have or previously had

Heart (surgery, disease, attack)	Kidney trouble	Tumors
Chest Pain	Ulcers	Hepatitis A, B or C
Congenital heart disease	Diabetes	Venereal Disease
Heart murmur	Thyroid problems	AIDS / HIV positive
High/Low blood pressure	Glaucoma	Cold sores / fever blisters
Mitral valve prolapse	Contact lenses	Blood transfusion
Artificial heart valve	Emphysema	Hemophilia
Pacemaker	Chronic cough	Sickle cell disease
Rheumatic Fever	Tuberculosis	Bruise easily
Arthritis / rheumatism	Asthma	Liver disease/jaundice
Cortisone medicine (steroids)	Hay fever/allergies/hives	Neurological disorders
Swollen ankles	Latex sensitivity	Epilepsy or seizures
Stroke	Sinus trouble	Fainting or dizzy spells
Diet (special / restricted)	Radiation therapy	Nervous / anxious
Artificial joints (hip, knee, etc.)	Chemotherapy	Psychiatric care

Do you have or have you had any disease, condition or problems not listed? If so, please describe: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medicine.

Patient / Guardian Signature and Date: _____