



Welcome

Thank you for selecting our exceptional dental healthcare team. Our primary commitment is to provide our patients with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form in ink. If you have any questions or need assistance please ask.

Date _____ Social Security # _____ Email _____ Cell _____

Patient Information (Confidential)

Name _____ Birthdate _____ Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full time Part-time

Patient's or Parent's Employer _____ Work Phone _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Phone _____

Birthdate _____ Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now? Yes No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, Please explain. Yes No

Have you been advised to take **Pre-Medication** antibiotics prior to your dental treatment? Yes No
If Yes, list PRE-MED taken. _____

Have you ever taken Fosamax, Actonel, Boniva or Reclast? Yes No

Are you taking Prolia or Forteo? Yes No

Have you ever received intravenously Aredia or Zometa? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you allergic to or have you had any reactions to:

Local Anesthetics (eg. novocaine) Yes No

Penicillin Yes No

Sulfa Drugs Yes No

Barbituates Yes No

Sedatives Yes No

Iodine Yes No

Aspirin Yes No

Any Metals (eg. nickel, mercury, etc.) Yes No

Latex Rubber Yes No

Other (Please list) _____ Yes No

Women Only:

Are you pregnant or think you may be? Yes No

Are you nursing? Yes No

Are you taking contraceptives? Yes No

Are you taking any medication(s) including over the counter medications and supplements? Yes No

If Yes, List _____

Do you have or have you had:

- | | | | | | |
|---------------------|--|----------------------|--|--|--|
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Dis. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MVP | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemo Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you take dietary supplements regularly? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you regularly take any of the following: | |
| Chest Pains/Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Garlic | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ginger | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ginko | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ginseng | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever/Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fish Oil | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vitamin E | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stents | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Echinacea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Valve Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | St. John's Wart | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Filters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kava | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Valerian | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Patient Dental History

- | | | | |
|--|--|--|--|
| Do your gums bleed while brushing/flossing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your teeth sensitive to hot or cold? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you clench or grind your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your teeth sensitive to sweet or sour? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you bite your lips or cheeks frequently? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel pain in any of your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had difficult extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have sores or lumps in your mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had prolonged bleeding following extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any head, neck or jaw injuries? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had any orthodontic treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you experienced any of the following: | | Do you wear dentures or partials? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, date of placement _____ | |
| Pain (joint, ear, side of face) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Difficulty in opening or closing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Difficulty in chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Smile/Cosmetic Evaluation

- If you could Change anything about your smile, what would you change? (For Example: Color, Shape, Spacing, Straighter, Silver Fillings, Missing Teeth, etc.) _____
- Have you had Botox/Dysport and/or Dermal Fillers (Juvederm, Restylane, Voluma, Radiesse) in the past? Yes No
- Would you be interested? Yes No
- What additional services would you like to learn about?
- | | |
|---|---|
| <input type="checkbox"/> Clenching/Grinding Treatments | <input type="checkbox"/> Facial Injectables/Fillers |
| <input type="checkbox"/> Straightening Crowded Teeth/Invisalign | <input type="checkbox"/> Improvement of Facial Lines/Wrinkles |
| <input type="checkbox"/> Correcting Facial Asymmetries | <input type="checkbox"/> Brow Lift |
| <input type="checkbox"/> Improving Thin Lips/Liplines | <input type="checkbox"/> Other _____ |

Snoring/Sleep Apnea

- | | |
|---|--|
| Do you snore more than three nights a week? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your snoring loud (can be heard through a door or wall)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has anyone ever told you that you briefly stop breathing or gasp when you are asleep? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel fatigued throughout the day? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Photo Release

I agree that Aesthetic Dentistry of Palm City, Inc. may use photographs of me, with or without my name, for example, such purposes as publicity, illustration, advertising and web content. I authorize the release of my photo(s). Yes No

Signature _____ Date _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental treatment to health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent) _____