My Best Smile

" Preserving Smiles for Generations"

Appointment Date, If Scheduled:	Time:
This Appointment is for: Me My Child	
Reason for your Visit:	
Whom may we thank for referring you?	

Patient Name

Last:	First:	Middle:	Nickname:

Patient Address

Street Address:	City:	State:	Zip:

Personal Information

Birthdate:	Age:	Grade (if school-aged):	M	F
Marital Status: M	S	D SS Number:		

Primary Insurance Information

Insurance Co.:	Group #:	Employer:
Address:		Phone:

Primary Insured's Information

Name:	Relationship to Patient:
Employer:	

Secondary Insurance Information

Insurance Co.:	Group #:	Employer:
Address:		Phone:

Secondary 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 you brush:	How often you floss:
How often you have dental examinations:	

What Dental aids do you use (toothpicks, proxibrush, etc.

Have you ever used topical fluoride?	Yes	No
Are you currently using topical fluoride?	Yes	No

Please Describe any dental problems you are currently experiencing.

	Yes	No
Sensitive to hot or cold		
Sensitive to sweets		
Sensitive to biting or chewing		
Any mouth odors or bad tastes?		
Do you frequently get cold sores, blisters or any other oral lesions?		
Do your gums bleed or hurt?		
Have your parents experienced gum disease or tooth loss?		
Have you noticed any loose teeth or change in your bite?		
Does food tend to become caught in between your teeth?		
If so,		
Do you bite your lips or cheeks regularly?		
Do you mouth breath while awake or asleep?		
Do you snore or have any sleeping disorders?		
Do you Smoke or chew tobacco or use other tobacco products?		
Do you clench or grind your teeth while asleep or awake?		
Hold foreign objects in your teeth (pencils, pipe, pins, nails, fingernails)?		
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?		

Have you ever had:	Yes	No
Orthodontic Treatment?		
Oral Surgery?		
Periodontal treatment (gum disease)?		
A bite plate or mouth guard?		
Teeth ground or bite adjusted?		
Serious injury to the mouth or head?		
If so, please describe:		

Have you ever experienced:	Yes	No
Clicking or popping of the jaw		
Pain in the joint, ear or side of face?		
Difficulty in opening or closing the mouth		
Head, neck or shoulder aches?		
Sore muscles in the neck or shoulders		
An upsetting dental experience?		
If so, please describe:		

Is there anything else about having dental treatment that you'd like us to know?	

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

Name:	Relationship:
Name:	Relationship:

Emergency Contact

Name:	Relationship:
Phone:	

Closet 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?	
If so, please describe:	

	Yes	No		Yes	No
Have you taken any medications or drugs in the last 2 years?			**Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs?**		
Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?			**Are you aware of having an allergic (or adverse) reaction to any substance or medications?**		
If yes, please list names and dosages:			**If yes, please specify:**		
Have you taken prescription medications for weight loss (diet pills)? Please indicate if you have taken any of the following:			**Have you been a patient in the hospital during the past 5 years?**		
Fen-Phen			**Are you pregnant or think you could be pregnant?**		
Pondimen			**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 murmer		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/yellow/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/psychological care	

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

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: