THE EXTRA SMILE

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely as you can. If you have any questions we would be glad to help you. We look forward to working with you in maintaining your dental health.

Patient information

Date_____/_____/_____ Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Name:_____ SS #_____

Address:_____ Email :_____

City:_____ State:_____ Zip:_____ Sex [ ] Male [ ] Female

Age:_____ Birth date _____/_____/_____ Married [ ] Widowed [ ] Single [ ] Partnered [ ]

Employer

Patient Employer _____ Occupation _____

Employer Address _____ Employer Phone _____-_____-_____

Primary Insurance

Person Responsible for account: _____ Birth date_____/_____/_____

Relationship to Patient _____ SS#_____-_____-_____

Insurance Company _____ Insurance Phone # _____-_____-_____

ID # _____ Group # _____

Dental History

Reason for today's visit_____ Date of last dental care _____

Former Dentist _____ Date of last X-rays _____

Check if you have had problems with any of the following;

Bad Breath [ ]
Bleeding gums [ ]
Sensitivity to hot/cold [ ]
Sensitivity when biting [ ]
Sensitivity to sweets [ ]
Periodontal treatment [ ]
Loose teeth or broken fillings [ ]
Clicking or popping jaw [ ]
Grinding teeth [ ]
Sensitivity to cold sores or mouth ulcers [ ]
Food collection between teeth [ ]

Are you interested in whitening Yes [ ] No [ ] What would you change about your smile?_____

How did you hear about us? _____ Who may we thank for referring you?_____

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Medical Information

Name:_____ Date of birth; _____/_____/_____

Emergency Contact:_____ Relationship:_____ Phone_(___)___-____

Primary Physician:_____ Phone (____)_____-_____

Specialist Physician(s):_____ Last visit date ___/____/_____ Phone(___)_____

Do you suffer from or currently have any of the following conditions

CAD (Angina, Heart Attack)		Multiple Sclerosis		COPD		Obstructive Sleep	
Heart Failure (weak heart)		Alzheimer's / Dementia		Emphysema		Headaches/ Migraines	
High Blood Pressure		Blood Disorder		Chronic Bronchitis		Glaucoma	
Low Blood Pressure		Bleeding Problems		Sinus / Hay Fever		Ulcers / Gerd	
Arrhythmia		Hepatitis		Allergies / Inhaler		Intestinal Problems	
Congenital Heart Defect		HIV / AIDS		Asthma		Auto Immune Disorder Lupus / Fibromyalgia	
Valve Disease / Murmur		Substance Abuse		Tuberculosis		Liver Disorder	
Artificial Heart Valve		Thyroid Disorder		Cancer		Kidney Disorder	
Endocarditic (Heart Infection)		Diabetes Mellitus		Physical Impairment		Bladder Disorder	
Stroke / TIA		Depression / Panic Attacks		Joint Replacement		Pregnant	
Seizures / Epilepsy		Psychosis / Mania		Organ Transplant		Breast Feeding	

Please list any medical problems you have that are not listed above:_____

_____

Have you ever had complications from local or general anesthetic? Y [ ] N [ ]

If yes please explain in detail_____

Please list any allergies to medication, foods, or any other substance:_____

Please list all medications you are taking_____

_____