PATIENT INFORMATION

Patient's Full Name____ Nickname or "Goes by"________________________

Birth Date______/______/______ Social Security Number____________________ Phone Number___________________________

Address, if different than Responsible Pary____

Emergency Contact, someone not living with the patient: Name_______________________________ Phone________________________

WE WANT TO HELP YOU GET THE SMILE YOU'VE ALWAYS WANTED

1. What is your present dental problem or concern?____

2. How do you feel about getting and maintaining a healthy smile?____

3. Would you like to know more about fresh breath?____

4. Are you pleased with the appearance of your teeth when you smile?____

5. Are there spaces between your teeth that you don't like?____

6. Are you pleased with the color of your teeth?____

7. Are you pleased with the shape of your teeth?____

8. Are you pleased with the appearance of your gums when you smile?____

9. Are your teeth...

   Chipped?____

   Protruding?____

   Hidden?____

   Crowded?____

10. Do you like the way your teeth fit together when you bite?____

11. Are there old fillings or dental treatments that you aren't happy with?____

12. If you could change anything about the appearance of your smile, what would that be?____

____

13. Is there anything about the shape or alignment of your jaw that you are not happy with?____

____

14. Have you ever had a serious/difficult problem associated with any previous dental work?____

____

15. Do you experience stress or anxiety when you visit a dental office?____

Name___________________________ Date of Birth _____/_____/_____

HEALTH INFORMATION

Do you have or have you ever had:	YES	NO	COMMENTS/UPDATES
Anemia..	______	______	______________________
Diabetes...	______	______	______________________
Osteoporosis……………………………………	______	______	______________________
Allergies	______	______	______________________
To Penicillin	______		______________________
To Codeine	______		______________________
To Local Anesthetic	______		______________________
To Iodine	______		______________________
To Latex	______		______________________
Other (please add comment)	______		______________________
Abnormal Heart Condition.....................................	______	______	______________________
Congenital Cardiac Malformations	______		______________________
Heart Murmur	______		______________________
Mitral Valve Prolapse	______		______________________
(with valvular regurgitation)	______		______________________
Abnormal bleeding from a cut................................	______	______	______________________
Asthma..	______	______	______________________
Rheumatic Fever...	______	______	______________________
Hepatitis...	______	______	______________________
Circle: Type A Type B Non-A Non-B			______________________
Have you been tested for the AIDS Virus?....................	______	______	______________________
Circle on: HIV Positive Tested Negative			______________________
Have you had a blood transfusion?................................	______	______	______________________
Do you have a prosthetic replacement?.........................	______	______	______________________
Are you now under the care of a physician?...................	______	______	______________________
Do you use tobacco?..	______	______	______________________
Are you pregnant?..	______	______	______________________
Are you taking hormones?...	______	______	______________________
Are you taking birth control pills?................................	______	______	______________________
Are you taking any medications (incl. over-the-counter)?	______	______	

If so, what?____

Date of last medical exam____ Blood Pressure____________________

Date of last dental visit____

Other physical condition(s)____

I hereby authorize the doctor to perform any and all forms of treatment and therapy, as well as prescribe any and all forms of medication that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit.

____ ______/______/______

SIGNATURE OF RESPONSIBLE PARTY- RELATIONSHIP DATE

Date	Service Rendered	Charge