Smiles N Braces
FAMILY DENTISTRY and ORTHODONTICS

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PATIENT INFORMATION

Name: Last First MI Nickname

Address: Street

City State Zip

Sex: ☐ Male ☐ Female Height: Weight:

Birthdate:

Occupation: Social Security #:

Employer: Driver's Licence #:

Phone: Home: ( )

Work: ( ) May we contact you at work? ☐ Yes ☐ No

Cell: ( ) Preferred Contact Method: ☐ Email ☐ Text ☐ Phone

Email:

How did you hear about us?

EMERGENCY CONTACT INFORMATION

Name: Phone: ( ) Relationship:

Name: Phone: ( ) Relationship:

INSURANCE INFORMATION

Primary Dental Carrier

Subscriber Name: SSN: DOB:

Employer: Insurance Co:

Group #: Insurance Co Phone: ( )

Relation to Patient:

Secondary Dental Carrier

Subscriber Name: SSN: DOB:

Employer: Insurance Co:

Group #: Insurance Co Phone: ( )

Relation to Patient:

INSURANCE AUTHORIZATION STATEMENT (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature: **Date:**

MEDICAL HISTORY & INFORMATION

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions!

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other

Y	N	
❑	❑	Do you Smoke or use Tobacco?
❑	❑	Do you use recreational drugs?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If yes, # of weeks:
❑	❑	Are you Nursing?

Do you take Blood Thinners? _____

Do you take any Bone Building Drugs? _____

Please list any medications you are taking: _____

_____

DENTAL HISTORY & INFORMATION

What is the reason for today's visit? _____

When was your last dental visit? _____

Prior Treatment

- ❑ Basic Cleaning
- ❑ Deep Cleaning
- ❑ Gum Surgery
- ❑ Braces
- ❑ Fillings
- ❑ Root Canal Treatment
- ❑ Crowns
- ❑ Implants
- ❑ Wisdom Teeth Removal

Habits

- ❑ Thumbsucking
- ❑ Nail biting
- ❑ Lip biting
- ❑ Tongue thrusting
- ❑ Teeth grinding
- ❑ Pencil chewing
- ❑ Jaw Joints/Muscles
  - ❑ Clicking
  - ❑ Clenching
  - ❑ Soreness

Currently Experiencing?

- ❑ Toothache
- ❑ Tooth sensitivity
- ❑ Sore gums
- ❑ Bleeding gums
- ❑ Bad breath
- ❑ Bad taste
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Any past dental trauma? _____

Sleep Apnea:

Snore? ☐ Yes ☐ No Daytime sleepiness? ☐ Yes ☐ No Feel rested in the morning? ☐ Yes ☐ No

Beverages:

Tea ☐ Coffee ☐ Wine ☐ Soda ☐ Other ☐ _____

Smile and Teeth:

Do you floss? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No Comments: _____

Interested in whitening? ☐ Yes ☐ No Comments: _____

Interested in straightening? ☐ Yes ☐ No Comments: _____

OTHER INFORMATION

How do you wish to be treated when you are at the dentist?

Quick 'wipe off the stain'? ☐ Thorough exam with proper recording and diagnostics? ☐

Has your prior dental experience been good? _____

What did you like *most* about your last dentist? _____

Why did you leave your last dentist? _____

What can we do to improve your dental experience? _____

TREATMENT AUTHORIZATION FORM

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____

Patient's Signature **Date**

If Patient requires a guardian

_____ _____

Guardian Signature **Date**

DOCTOR'S NOTES

Doctor's Sign & Date