PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, guardian's name _____ Preferred number _____(Cell / Home/ Work)

Mailing address _____ Apt #_____City _____ State _____ Zip _____

Email address _____Relationship status_____

Employer _____ Occupation _____

Whom may we thank for referring you to our office? _____

Emergency Contact's Name _____ Phone Number_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co._____ Group number_____ Your Social Security number: _____

Covered by spouse's insurance? ❑ Yes ❑ No

Spouse's name _____ Spouse's employer _____

Spouse's dental insurance company _____ Group number _____

Spouse's date of birth _____ Social Security number _____

Smiles Chandler Dental History

How may we help you today? _____

When was your last dental visit? _____

When was your last dental cleaning? _____

Why did you leave your last dentist? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold or anything else? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes when? _____ ☐ No

How many times do you: Floss/week? _____ Brush/day? _____

Do you have any pain/discomfort in your jaw joint? ☐ Yes ☐ No

Are you under more stress than usual? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

How can we better accommodate you during your dental visit? _____

_____

We offer a wide range of services to maintain and enhance your smile. Please circle any services below that you would like to discuss during your visit.

Tooth Whitening Invisalign Sealants Bonding Implant /Implant Crowns Night/Sport Guards Partials/Dentures Crown and Bridge Tooth Colored Fillings

MEDICAL HISTORY

Although dental personnel 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 medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____
Are you now under the care of a physician? Yes ❑ No ❑
Are you pregnant or do you think you may be pregnant? Yes ❑ No ❑ If yes, expected delivery date: _____
Are you nursing? Yes ❑ No ❑ Are you taking birth control pills? Yes ❑ No ❑
Do you smoke? Yes ❑ No ❑ If yes, how much? _____
Are you taking any medication now? Yes ❑ No ❑ If yes, names of medications and problems for which they are taken:
Medication 1) _____ Taken for _____ 3) _____ Taken For _____
2) _____ Taken for _____ 4) _____ Taken For _____

Do you use tobacco? Yes ❑ No ❑
Have you ever required a blood transfusion? Yes ❑ No ❑
Do you or have you used controlled substances? Yes ❑ No ❑
Have you ever taken Fen-Phen or Redux? Yes ❑ No ❑
Are you wearing contact lenses? Yes ❑ No ❑
Do you bruise easily? Yes ❑ No ❑

Have you ever had (please check-mark appropriate boxes):

Abnormal blood pressure High ❑ Low ❑ No ❑
AIDS/HIV Yes ❑ No ❑
Anemia Yes ❑ No ❑
Arthritis Yes ❑ No ❑
Asthma or hay fever Yes ❑ No ❑
Allergies Yes ❑ No ❑
Back problems Yes ❑ No ❑
Cancer Yes ❑ No ❑
Chemical dependency Yes ❑ No ❑
Cold sores/Fever blisters Yes ❑ No ❑
Common cold Yes ❑ No ❑
Congenital heart lesions Yes ❑ No ❑
Diabetes Yes ❑ No ❑
Drastic weight loss Yes ❑ No ❑
Eating disorders Yes ❑ No ❑
Epilepsy/Seizures Yes ❑ No ❑
Excessive urination and/or thirst Yes ❑ No ❑
Fainting spells Yes ❑ No ❑
Glaucoma Yes ❑ No ❑
Heart disease Yes ❑ No ❑
Heart murmur Yes ❑ No ❑
Heart surgery Yes ❑ No ❑
Hepatitis Yes ❑ No ❑
Jaundice Yes ❑ No ❑
Joint replacement or implant Yes ❑ No ❑
Kidney trouble Yes ❑ No ❑
Mental health care Yes ❑ No ❑
Lymph node enlargement (swollen glands) Yes ❑ No ❑
Mitral valve prolapse Yes ❑ No ❑
Night sweats Yes ❑ No ❑
Pacemaker Yes ❑ No ❑
Persistent diarrhea Yes ❑ No ❑
Prolonged bleeding Yes ❑ No ❑
Rheumatic fever Yes ❑ No ❑
Sexually transmitted disease Yes ❑ No ❑
Sinus trouble Yes ❑ No ❑
Swollen ankles Yes ❑ No ❑
Stroke Yes ❑ No ❑
Thyroid problem Yes ❑ No ❑
Tuberculosis or lung disease Yes ❑ No ❑
Ulcers Yes ❑ No ❑
X-ray treatments for cancer Yes ❑ No ❑

If you have entered "yes" to any of the above, please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocaine Yes ❑ No ❑
Penicillin or other antibiotics Yes ❑ No ❑
Sulfa drugs Yes ❑ No ❑
Barbiturates, sedatives, or sleeping pills Yes ❑ No ❑
Codeine Yes ❑ No ❑
Aspirin Yes ❑ No ❑
Iodine Yes ❑ No ❑
Any metal (e.g. gold, nickel, etc.) Yes ❑ No ❑
Latex/Rubber Yes ❑ No ❑
Tylenol Yes ❑ No ❑

Other (please list) _____
Have you had any other serious illness, hospitalization, or accident? _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release (Your Office Name) to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____