# The Smile Studio
A FAMILY DENTISTRY

**Thank you for selecting our dental healthcare team**
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us –we will be happy to help.

## *Patient Information* (CONFIDENTIAL)

Date: _____

Patient Name: _____
*Last name*

_____
*First name* *Middle Initial*

Preferred Name (Nickname): _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: ☐ M ☐ F Birthdate: _____ Age: _____
*MM/DD/YYYY*

☐ Single ☐ Married ☐ Seperated ☐ Widowed

☐ Divorced ☐ Minor ☐ Partnered for _____ years.

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Spouse's Name: _____

Birthdate: _____ SS#: _____

Spouse's Employer: _____

## *Dental Insurance*

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance?: ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____ SSN: _____

Relationship to patient: _____

Insurance Co.: _____

Group #: _____

### *Assignment and Release*

I certify that I, and/or my dependent(s) have insurance coverage with:

_____

and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurancel authorise the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

## *Phone Numbers*

Home: (_____) _____ Work: (_____) _____ Ext: _____ Cell Phone: (_____) _____

Spouse's Work: (_____) _____ Best time and place to reach you: _____

## IN CASE OF EMERGENCY, CONTACT *(Specify someone who does not live in your household)*

Name: _____ Reltionship: _____

Home: (_____) _____ Work: (_____) _____

## *Additional information*

Who can we thank for referring you?

☐ Website ☐ Walk-in ☐ Social Media ☐ Yelp ☐ Email

☐ Friend/Family Name: _____ ☐ Other: _____

How did you find our contact info?

☐ Website ☐ Walk-in ☐ Social Media ☐ Yelp ☐ Email

☐ Friend/Family Name: _____ ☐ Other: _____

*--- Turn Page Over ---*

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## *Dental History*

Reason for today's visit: _____

_____

Date of last dental visit: _____

Date of last dental x-ray: _____

*(Place a mark on "yes" or "no" to indicate if you have had any of the following)*

| | | | |
|---|---|---|---|
| Bad breath? | ☐ Yes ☐ No | Lip or cheek biting? | ☐ Yes ☐ No |
| Bleeding gums? | ☐ Yes ☐ No | Loose teeth or broken fillings? | ☐ Yes ☐ No |
| Blister or lips or mouth? | ☐ Yes ☐ No | Mouth breathing? | ☐ Yes ☐ No |
| Burning sensation on tongue? | ☐ Yes ☐ No | Mouth pain while brushing? | ☐ Yes ☐ No |
| Chew on one side of mouth? | ☐ Yes ☐ No | Orthodontic treatment? | ☐ Yes ☐ No |
| Cigarette, pipe or cigar smoking? | ☐ Yes ☐ No | Pain around ear? | ☐ Yes ☐ No |
| Clicking or popping jaw? | ☐ Yes ☐ No | Periodental treatment? | ☐ Yes ☐ No |
| Dry Mouth? | ☐ Yes ☐ No | Sensitivity to cold temp? | ☐ Yes ☐ No |
| Fingernail biting? | ☐ Yes ☐ No | Sensitivity to heat? | ☐ Yes ☐ No |
| Food collection between teeth? | ☐ Yes ☐ No | Sensitivity to sweets? | ☐ Yes ☐ No |
| Foreign object? | ☐ Yes ☐ No | Sensitvity when biting? | ☐ Yes ☐ No |
| Grinding teeth? | ☐ Yes ☐ No | Sores or growths in your mouth? | ☐ Yes ☐ No |
| Gums swollen or tender? | ☐ Yes ☐ No | How often do you floss? _____ | |
| Jaw pain or tiredness? | ☐ Yes ☐ No | How often do you brush? _____ | |

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## *Health History*

Physician's Name: _____ Date of Last Visit: _____

Have you ever used a bisphosphonate medication? (Common brands include Fosamax, Actonel, Atelvia, Didronel, Boniva). ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names phantermine), Pondimin (Fenfluramin) and Redux (dexfenfluramine). ☐ Yes ☐ No

*(Place a mark on "yes" or "no" to indicate if you have had any of the following)*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Neurological Problems | ☐ Yes ☐ No |
| Allergies | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Endocarditis | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No |
| Angina | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No |
| Anxiety | ☐ Yes ☐ No | Fainting or Dizziness | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Fibromyalgia | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Asthma or Hay Fever | ☐ Yes ☐ No | Heart Attack | ☐ Yes ☐ No | Seizures | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| | | Hemophilia | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Blood Transfusion | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Cancer Therapy | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Jaw Pain | ☐ Yes ☐ No | Tonsilitis | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Claustrophobia | ☐ Yes ☐ No | Leukemia | ☐ Yes ☐ No | Tumor or Growth on head or neck | ☐ Yes ☐ No |
| Congenital Heart Lesions | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | | |
| Contact Lenses | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Ulcer | ☐ Yes ☐ No |
| COPD | ☐ Yes ☐ No | Measles or Mumps | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Cortisone Treatments | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Cough Persistent or Bloody | ☐ Yes ☐ No | Nasal Obstruction | ☐ Yes ☐ No | | |

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check the medications you are presently taking, you have taken in the past or you have had an adverse reaction to:

| | Presently Taking | Taken in the Past | History of Reaction |
|---|---|---|---|
| Anesthetics, Locally Injected | ☐ | ☐ | ☐ |
| Anesthetics, General | ☐ | ☐ | ☐ |
| Antacids | ☐ | ☐ | ☐ |
| Anti-anxiety Medications | ☐ | ☐ | ☐ |
| Anti-depressants | ☐ | ☐ | ☐ |
| Antihistamines | ☐ | ☐ | ☐ |
| Daily Aspirin Regimen | ☐ | ☐ | ☐ |
| Birth Control Pills | ☐ | ☐ | ☐ |
| Blood Pressure Medications | ☐ | ☐ | ☐ |
| Codeine, Demerol or other Analgesics | ☐ | ☐ | ☐ |
| Cortisone or other Steroids | ☐ | ☐ | ☐ |
| Coumadin, Heparin, Warfarin or other blood thinners | ☐ | ☐ | ☐ |
| Dilantin | ☐ | ☐ | ☐ |
| Diuretics (water pills) | ☐ | ☐ | ☐ |
| Ibuprofen (Motrin) | ☐ | ☐ | ☐ |
| Tylenol (Acetomeniphen) | ☐ | ☐ | ☐ |

| | Presently Taking | Taken in the Past | History of Reaction |
|---|---|---|---|
| Fen-phen (Ionimin, Adipex, Fastin, Phentermine, Pondimin, Fenfluramine, Redux Dexfenfluramine | ☐ | ☐ | ☐ |
| Heart Medications such as Digoxin, Nitroglycerin or Digitalis | ☐ | ☐ | ☐ |
| Insulin or Diabetes Meds | ☐ | ☐ | ☐ |
| Sedatives or Tranquilizers | ☐ | ☐ | ☐ |
| Sleeping Pills (Barbiturates) | ☐ | ☐ | ☐ |
| Thyroid medication such as Synthroid, Levoxyl or Levothyroxine | ☐ | ☐ | ☐ |
| Herbal or natural remedies | ☐ | ☐ | ☐ |

Please Specify: _____

Adverse Reaction to any other medications or drugs? ☐ Yes ☐ No

Please Specify: _____

_____

_____

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## *Health History (continued)*

Please list the other medications you are currently taking and what conditions you are taking them for.
Please include vitamins and supplements and over the counter medications:

| Medication | Condition | Prescribing Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Pharmacy Name: _____ Phone: (_____) _____

FOR WOMEN:

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Are you nursing? ☐ Yes ☐ No

Have you had any serious illnesses or surgeries? ☐ Yes ☐ No

If yes, please describe: _____

## *Tobacco, Alcohol & Caffiene Use*

Tobacco Use? ☐ Yes ☐ No Packs per day: _____

Alcohol, Beer, Wine Consumption? ☐ Yes ☐ No Drinks per day: _____

Street Drug Use? ☐ Yes ☐ No Times per day: _____

Caffiene Use? ☐ Yes ☐ No Cups per day: _____

High Stress? ☐ Yes ☐ No Reason: _____

## *Final Information*

Do you have any other health needs you should bring to our attention?: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____ Relationship to Patient _____