NAME ______________________ ADDRESS ______________________

HOME PHONE ______________________ CITY ______________________

WORK PHONE ______________________ STATE ____________ ZIP ____________

SOCIAL SECURITY NUMBER ______________________ SPOUSE'S NAME ______________________

DATE OF BIRTH ______________________ SPOUSE'S EMPLOYER ______________________

SEX ______________________ SPOUSE'S WORK PHONE ______________________

MARITAL STATUS: ______________________ SPOUSE'S SOCIAL SECURITY NUMBER ______________________

PHYSICIAN'S NAME ______________________ LAST PHYSICAL EXAM ______________________

PHONE ______________________ LAST DENTAL EXAM ______________________

YOUR EMPLOYER ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

PHONE ______________________

NAME OF A PERSON NOT LIVING WITH YOU ______________________

PHONE ______________________

REFERRED BY: ______________________

____

E-Mail

YOUR INSURANCE COMPANY ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

PHONE ______________________

GROUP NUMBER ______________________

GROUP NAME ______________________

PERSON TO CONTACT ______________________

COVERAGE TYPE ______________________

In order to minimize bookkeeping costs, payment is required at time of treatment.

- ☐ PAYMENT BY CASH OR CHECK
- ☐ PAYMENT BY VISA OR MASTERCARD
- ☐ DENTAL INSURANCE - DEDUCTABLE AND CO PAYMENT REQUIRED AT TIME OF TREATMENT.

I authorize Dr Jeffrey Smith and delegates to perform the dental procedures advisable for myself/child including the use of local anesthetics and/or nitrous oxide analgesia.

______________________ SIGNATURE OF PATIENT,PARENT OR GUARDIAN ____________ DATE

Thank you for completing the following
confidential information.

PLEASE ANSWER ALL QUESTIONS.

MEDICAL /DENTAL HISTORY

REASON FOR TODAY'S VISIT ____________________

Please state whether you have suffered any of the following

YES	NO		YES	NO		YES	NO	
❑	❑	RHEUMATIC FEVER	❑	❑	RESPIRATORY PROBLEMS	❑	❑	DIABETES
❑	❑	HEART MURMUR	❑	❑	KIDNEY DISEASE	❑	❑	SEIZURES
❑	❑	CONGENITAL HEART DISORDER	❑	❑	VENEREAL DISEASE	❑	❑	MALIGNANCY
❑	❑	HEART SURGERY	❑	❑	AIDS	❑	❑	HEPATITIS
❑	❑	PROSTHETIC VALVES	❑	❑	HIGH BLOOD PRESSURE	❑	❑	PREGNANT?
❑	❑	OTHER HEART CONDITON	❑	❑	TUBERCULOSIS	❑	❑	ASPIRIN ALLERGY
❑	❑	PENNICILLIN ALLERGY	❑	❑	CODEINE ALLERGY			

❑ ❑ BLOOD TRANSFUSION, date ____________

❑ ❑ ARE YOU ALLERGIC TO ANY MEDICATION NOT LISTED ABOVE? PLEASE LIST: ____________

____

❑ ❑ ARE YOU TAKING ANY MEDICATION AT THIS TIME? PLEASE LIST: ____________

____

Please describe any symptoms.

YES	NO		YES	NO		YES	NO	
❑	❑	BLEEDING,SORE GUMS	❑	❑	BAD TASTE /BREATH	❑	❑	LOOSE TEETH
❑	❑	BURNING TONGUE, LIPS	❑	❑	FREQUENT BLISTERS	❑	❑	SWELLING/LUMPS
❑	❑	ORTHO TREATMENT(BRACES)	❑	❑	BITING LIPS/CHEEKS	❑	❑	FILLINGS

YES	NO		YES	NO	
❑	❑	FOOD IMPACTION	❑	❑	CLENCHING /GRINDING
❑	❑	DIFFICULTY OPENING OR CLOSING JAW	❑	❑	PAIN IN OR AROUND EARS
❑	❑	CLICKING/POPPING JAW	❑	❑	HAVE YOU LOST ANY TEETH?
❑	❑	ARE YOUR TEETH SENSITIVE TO HOT?	❑	❑	ARE YOUR TEETH SENSITIVE TO SWEETS
❑	❑	ARE YOUR TEETH SENSITIVE TO COLD?	❑	❑	ARE YOUR TEETH SENSITIVE TO BITING?

❑ ❑ ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH?

❑ ❑ DO YOU HAVE DISCOLORED TEETH THAT BOTHER YOU?

❑ ❑ WOULD YOU LIKE TO KNOW MORE ABOUT PERMANENT REPLACEMENT?

❑ ❑ ARE YOU INTERESTED IN TOOTH-COLORED FILLINGS?

❑ ❑ ARE YOU INTERESTED IN IMPLANTS?

Do you use the following and how often?

❑ ❑ TOOTH BRUSH ____________

❑ ❑ DENTAL FLOSS ____________

❑ ❑ FLUORIDE RINSE ____________

IS YOUR TOOTH BRUSH : SOFT ❑ MEDIUM ❑ HARD ❑

Patients Name ______________________________ Date ______________

Are You a Candidate For Cosmetic Dentistry?

self-analysis:

Why change your smile? Don't if you're happy with it, but ask yourself the following questions:	*Yes*	*No*
1. Does your self-confidence lessen when smiling in front of other people?	___	___
2. Do you ever put your hand up to cover your smile?	___	___
3. Do you feel you photograph better from one side of your face?	___	___
4. Is there someone you think has a better smile than you?	___	___
5. Do you look at magazines and wish you had a smile as pretty as the model's?	___	___
6. When you read a fashion magazine, are your eyes drawn to the model's smile?	___	___
7. When you look at your smile in the mirror, do you see a minor defect in your gums or in any of your teeth?		
8. Do you wish your teeth were whiter?	___	___
9. Do you wish your gums looked better?	___	___
10. Do you wish you showed more or fewer teeth when smiling?	___	___
11. Do you think you show too much or too little gum tissue when you smile?	___	___
12. Do you wish you had longer or shorter teeth?	___	___
13. Would you prefer wider or narrower teeth?	___	___
14. Are your teeth too square or too round?	___	___
15. Do you wish your teeth were shaped differently?	___	___

If you answered "NO" to every question except #1, #9 and #15, you are apparently content with your smile.

TMD *Screening Questionnaire*

(Temporomandibular joint/jaw joint)

	Yes	*No*		Degree of Discomfort *mild–1–2–3–4–5–> severe*
16.	___	___	Do you suffer from frequent headaches (e.g. more than once a week)?	______
17.	___	___	Do you ever have pain, discomfort, or other sensations (ringing, roaring, stuffiness, etc.), in front of or behind the ear?	______
18.	___	___	Do you ever have pain, discomfort, or other sensations (tiredness, pulling, weakness, burning, etc.) about the ears, temples, neck or cheek?	______
19.	___	___	Does it ever hurt to chew or is your bite ever uncomfortable or unusual?	______
20	___	___	Does it ever hurt to open wide, take a big bite or yawn?	______
21.	___	___	Does your jaw ever make noise (popping, cracking, grating, etc.) or does your jaw ever lock?	______
22.	___	___	Have you had any serious trouble associated with any previous dental treatment? If so, explain. ______________________________ ______________________________	______
23.	___	___	Have you ever had an injury to your head, neck or jaw (e.g. due to an auto accident)?	______
24.	___	___	Have you previously been treated for jaw or joint problems? If so, when? ______________________________	______
25	___	___	Are you wearing removable dental appliances (e.g. bite plane, retainer, nightguard, etc.)?	______

Chief Dental Complaint? ______________________________

____

Dental management considerations: ______________________________

____