

Center for
P r e m i e r • D e n t i s t r y
B I G W I G I D G U F I S F L A
for a better life

Welcome!

So we may provide you with the best possible care and get to know you better,
please complete these personal information, medical & dental history forms.
All information is confidential.

Date: _____
Title: () Mr. () Mrs. () Ms. () Dr. Preferred to be called: _____
Name: First _____ Last _____ MI _____
Residence: _____
City _____ State _____ Zip _____
Secondary Residence: _____
City _____ State _____ Zip _____
Home Phone: _____ Work: _____
Cell: _____ Pager: _____
E-mail address: _____ Date of birth: ____ / ____ / ____
Social Security # _____ - _____ - _____ Sex: M F Marital Status: _____
How were you referred to our office? Family/Friend: ___ Who: _____
Sign ___ Other _____
Personal Interests: _____
Physician's name: _____ Phone #: _____
Date of last visit: _____ Pharmacy: _____ Phone: _____
In case of emergency, contact: _____ Phone: _____

Employment Information

Employer: _____ Occupation: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____ Work Phone: _____

Insurance Information

Do you have dental insurance? Yes or No Please present your insurance card.
Insured's Name: _____ Employer's Name: _____
Insured's Social Security #: _____ - _____ - _____ Date of birth: ____ / ____ / ____
Insurance Company: _____ Group#: _____

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PATIENT MEDICAL HISTORY

General Questions. This questionnaire will be used by your dentist to help treat you safely. Please answer all questions as accurately as possible.

Do you have, or have you had any history of the following?

	Yes	No		Yes	No
AIDS/ HIV			Hepatitis / Jaundice		
Allergy to latex			High Blood Pressure/Hypertension		
Anemia			Irregular heart beat		
Angina pectoris / Chest pain			Kidney disease		
Arthritis			Liver disease		
Artificial joints			Mitral valve prolapse		
Asthma			Organ transplant		
Bleeding disorder			Pacemaker/Implanted defibrillator		
Cancer			Prosthetic (artificial) heart valve		
Chemotherapy			Psychiatric treatment		
Colitis / Intestinal problems			Radiation therapy		
Diabetes			Renal dialysis		
Emphysema			Rheumatic fever		
Epilepsy / Seizure			Sexually transmitted disease		
Heart attack			Stomach ulcer		
Heart disease			Stroke		
Heart or bypass surgery			Thyroid disease		
Heart Murmur			Tuberculosis (TB)		

Have you ever taken an appetite suppressant? (Such as Fen-Phen) _____

Do you smoke tobacco? _____ How much do you smoke? _____

How long have you smoked? _____

Do you use alcohol? _____ How many drinks per week? _____

Do you use recreational drugs? _____ What type? _____

Last recreational drug use? _____

For women only: Do you believe you are presently pregnant? _____

Are you currently taking Birth Control Pills? _____

Please turn over to complete 2nd page

Thank You

Please list any allergies:

Please list any medications:

Doctors notes:

Consent for Treatment

I, hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

Patient's signature: _____ Date: _____

Guarantor's signature: _____ Date: _____

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DENTAL HISTORY AND SMILE ANALYSIS

When was your last dental appointment? _____

When was your last dental cleaning? _____ Dental X-rays? _____

Are you having any problems at this time? _____

Are your teeth sensitive to any of the following? (please circle)

Heat Cold Sweets Biting

Have you ever been told you have gum disease? _____

Have you ever experienced: (please circle)

Discomfort, popping, clicking or locking of your jaw?	Yes	No
Pain upon chewing, opening wide or yawning?	Yes	No
Grinding or clenching your teeth?	Yes	No
Frequent headaches, neck or shoulder aches?	Yes	No
Loose teeth or changes in your bite?	Yes	No
Do you have a night guard?	Yes	No

On a scale from 1-10 (10 being best) how would you rate your:

Dental Health: _____ Your Smile: _____

Is there anything that concerns you about your smile? (color, spaces, chips, unsightly crowns or restorations, etc...) _____

Do you have any concerns about your old fillings or restorations? _____

If possible, would you like whiter teeth? _____

If you could wave a magic wand over your smile, what would you like to see?

With the advent of our modern technology and clinical expertise our doctors can create dramatic improvements in one's smile. Would you like the doctor to discuss the possible treatment options that address your concerns? _____ Yes _____ No

Our doctors have the special equipment to aid in computer assisted smile design; meaning we can show you via computer a simulated custom designed smile for you that you can view before any treatment is done; is this something that would be of interest to you? _____ Yes _____ No

Name _____ Date _____