

WELCOME!

DISTINCTIVE SMILES DENTAL

Thank you for choosing us for your dental care.
Please fill in this form completely.

Name of person responsible for account (Person with PRIMARY INSURANCE)

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip _____

Telephone (Home) () _____ (Work) () _____

Birthdate _____ Social Security # _____ Sex _____ (M or F) Marital Status _____

Employer Name _____ Employer Address _____

City _____ State _____ Zip _____ Referred By _____

Dental Insurance Co. _____ Phone () _____

Address _____

City _____ State _____ Zip _____ Group Number _____

E-mail address _____

Name of spouse of person named above:

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ Sex _____ (M or F) Social Security # _____

Employer Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Dental Insurance Co. _____ Phone () _____

Address _____

City _____ State _____ Zip _____ Group Number _____

Dependents:

Name	Date of Birth	Sex	Dental Insurance Through
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the dental needs of myself and my family. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent of Child) _____ Date _____

Distinctive Smiles Dental

PATIENT DENTAL HISTORY

Purpose of initial visit? _____

How long since last visit? _____

How long since last cleaning? _____ Were x-rays taken? _____

Any discomfort/sensitivity or pain? _____ If yes describe? _____

How often do you brush? _____ Floss? _____

Do your gums bleed? _____ Do you have bad breathe or taste? _____

Do you consume a lot of sweets and soda? _____ Are your teeth sensitive to sweets? _____

Are you pleased with the appearance of your teeth? _____ Their color? _____

Do you have missing teeth that have not been replaced? _____ If yes for how long _____

Do you have crooked teeth? _____ Do you now wear braces? _____ previously worn braces? _____

Do you have pain in your jaw joints (TMJ)? _____ Difficulty in opening your mouth ? _____

Do you grind your teeth at night? _____ wear a night guard? _____

Does dental treatment make you fearful? _____ Do you have a strong gag reflex? _____

Have you had dental implants placed? _____ If yes how many? _____

Have you had gum treatments? _____ If yes what type? _____

Do you wear complete dentures? _____ upper/lower (circle) If yes how old are they? _____

Do you wear partial dentures? _____ upper/lower (circle) If yes how old are they? _____

CHILDREN AND ADOLESCENTS

Does your child have a favorite nickname? _____

Is this your child's first visit in a dental office? _____

Does your child have a finger sucking habit? _____

Has this child ever had an unfavorable experience in a physician or dentists office? _____

Comments which may help us in the treatment of your child _____

PATIENT, PARENT, OR GUARDIAN SIGNATURE _____ DATE _____

Distinctive Smiles Dental

Patient Medical History

Patient's Name _____ Date of Birth _____

Sex _____ (M or F) Height _____ Weight _____ Date of last medical check up _____

Physicians Name _____ Phone () _____

DOES THIS PATIENT HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEM?

Rheumatic Fever	YES NO	Stroke	YES NO	Glaucoma	YES NO
Heart (attack, disease)	YES NO	Epilepsy or seizures	YES NO	Cancer/Tumor	YES NO
Low Blood Pressure	YES NO	Hepatitis, liver disease	YES NO	Radiation/Chemotherapy	YES NO
High Blood Pressure	YES NO	Arthritis	YES NO	Blood transfusion	YES NO
Mitral valve prolapse	YES NO	Gout	YES NO	Venereal disease	YES NO
Hemophilia	YES NO	Kidney disease	YES NO	Drug/Alcohol Addiction	YES NO
Heart pacemaker	YES NO	Organ transplant	YES NO	Mental Illness	YES NO
Artificial Heart Valve	YES NO	Thyroid disease	YES NO	Asthma/Hay fever	YES NO
Anemia	YES NO	Diabetes	YES NO	Sinus problems	YES NO
Scarlet fever	YES NO	Tuberculosis	YES NO	Back or neck injury	YES NO
Artificial joints	YES NO	Stomach/Intestinal disease	YES NO	TMJ/Jaw joint pain	YES NO
HIV/AIDS	YES NO	Emphysema/Lung disease	YES NO	Anorexia/Bulimia	YES NO

Do you have any other disease, condition or problem not listed? Describe _____

Have you had previous surgery, hospitalization? _____

What drugs, medications or herbal remedies are you taking? _____

Do you wish to speak privately to the dentist about any problem? _____

Are you allergic to any medicines or materials? _____

Women: Pregnant? Y/N If yes what month _____ Trying to get pregnant Y/N Nursing Y/N Oral contraceptives Y/N

Do you smoke? Y/N If yes, how much/day _____ for how long _____ Did you smoke previously _____ for how long _____

Do you consume more than 3 oz of alcohol per day? Y/N

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

PATIENT, PARENT, OR GUARDIAN SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____