changing smiles, changing lives

smile ADVANCED DENTAL CENTER

Patient Name: Birth Date: Date Created:

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 you will receive.
Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Has your weight changed by more than 10 pounds?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs on a daily basis?	◯ Yes ◯ No	If yes
Do you need an antibiotic prior to dental treatment ?	◯ Yes ◯ No	If yes
Do you wake up short of breath or very tired?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No	Artifical Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No
Artifical Joint ◯ Yes ◯ No	Asthma/Sinus trouble ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No
Tonsillitis ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	Tobacco Use ◯ Yes ◯ No		

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Do you feel nervous receiving Dental Treatment?	◯ Yes ◯ No	
Do you want to know about your dental issues?	◯ Yes ◯ No	
Have you had orthodontics in the past or hope to have orthodontics in the future?	◯ Yes ◯ No	

Are you concerned about:

Missing Teeth	◯ Yes ◯ No
Gum Disease	◯ Yes ◯ No
Bad Breath	◯ Yes ◯ No
Your smile	◯ Yes ◯ No
Preventive care only	◯ Yes ◯ No
Comprehensive care	◯ Yes ◯ No
Cost	◯ Yes ◯ No

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____
Preferred Name: _____
Home Phone: _____
Work Phone: _____ Cell Phone: _____
Which number is best to confirm appointments? _____
DOB: _____ ❑ Male ❑ Female
SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer:_____
E-mail Address: _____
Name of Physician: _____
Physician Phone: _____
Emergency Contact: _____
Relationship: _____ Phone: _____
How did you hear about our office?
_____

New Patient Profile

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can make you as comfortable as possible.

- Please rate in order of value, what is most important to you in your dental care:

____ Preventative Care
____ Only what is necessary at the time: Cost is important
____ Other_____

- Please rate as in #1, what is most important to you in your relationship with a Dentist:

____Show me what he/she is doing or planning to do so I can clearly see what is happening
____Listen to my concerns and explain what needs to be done so I can clearly hear and understand treatment
____Make sure I feel comfortable and informed at all times

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- Are you concerned about any of the following:
  ❑ Replace missing teeth ❑ Eliminating any disease present in my mouth
  ❑ Gum disease ❑ Bad breath ❑ The appearance of your smile

- Please circle the level of fear you have regarding dental treatment (10 being the most fearful and 1 being the least)

1 2 3 4 5 6 7 8 9 10

- I would like to know more about these options to maximize my comfort during my visits:

❑ Music and earphones ❑ Nitrous Oxide (laughing gas)
❑ Sedation Medication ❑ Extensive Sedation

- Is keeping your natural teeth important to you? ❑ Yes ❑ No

- I would like to keep my natural teeth until_____

- When we review your treatment plan with you, would you like to know (Please check one)

___ The big picture of what needs to be done
___ All the treatment details along the way