PLANO SMILE CENTER DENTISTRY

Patient Information

Name _____ Preferred Name _____
Last First Middle

Birthdate: _____ SSN: _____ Sex: ☐ Male ☐ Female
Month Day Year

Email address: _____ Phone number: _____ Alt. Phone number_____

Address: _____
Street Apt./Unit/Bldg City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Minor

Spouse Information (if applicable): _____ Spouse Birthdate _____
Month Day Year

Spouse SSN: _____ Spouse Occupation: _____

Spouse Phone number:_____ Spouse Employer: _____

Employment Information

Employment Status
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Retired ☐ Home Maker ☐ Unemployed

Employer: _____ Employee Phone Number _____

Guardians of Minor

If the patient is not a minor, please disregard this section.

Who is accompanying the child? Name:_____
Accompanying persons relation to patient: ☐ Foster ☐ Step ☐ Nanny ☐ Other:_____

Who does the patient live with? ☐ Guardian 1 ☐ Guardian 2 ☐ Guardian 1 and 2 ☐ Other:_____

Guardian 1 Name_____ Guardian 1 Relationship to Patient:_____
First Last

Guradian 1 Birthdate: _____ Guardian 1 SSN:_____
Month Day Year

Guardian 1 Email Address:_____ Guardian 1 Phone Number:_____
Guardian 1 Address:_____
Street Apt./Unit/Bldg City State Zip Code

Guardian 1: Employer:_____ Guardian 1 Employer Phone Number: _____

Guardian 1 Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Other:_____

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Guardian 2 Name:_____ Guardian 2 Relationship to Patient: _____
First Last

Guardian 2 Birthdate: _____ Guardian 2 SSN:_____
Month Day Year

Guardian 2 Email Address:_____ Guardian 2 Phone Number: _____

Guardian 2 Address:_____
Street Apt./Unit/Bldg City State Zip Code

Guardian 2: Employer:_____ Guardian 2 Employer Phone Number: _____

Guardian 2 Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Other:_____

Responsible Party is: ☐ Same as Guardian 1 ☐ Same as Guardian 2 ☐ Other:_____

Emergency Contact

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Address:_____
Street Apt./Unit/Bldg City State Zip Code

Phone number: _____ Alt. Phone number:_____

Responsible Party/ Billing Information

If the patient is the responsible party, please disregard this section

Relationship to Patient: _____

Name: _____ Preferred Name:_____

Birthdate:_____ SSN:_____
Month Day Year

Sex: ☐ Male ☐ Female Email Address: _____

Address:_____
Street Apt./Unit/Bldg City State Zip Code

Phone number: _____ Alt Phone Number:_____

Employer:_____ Employer Phone Number:_____

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page are correct to the best of my knowledge.

_____

Signature Date

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Referral Information

Please share with us how you heard about our office. Thank you!

☐ Internet, if so, what website did you use? _____
☐ Family Member, if so, who? _____
☐ Friend, if so, who? _____
☐ Pediatrician/Physician, if so, who? _____
☐ Dentist/ Dental Office, if so, who? _____
☐ Insurance, if so, which insurance company?_____
☐ School/Daycare, if so, please provide the name. _____
☐ Ad, please provide the name of ad. _____
☐ Other:_____

Dental History (confidential)

How do you feel about dental treatment? ☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very Anxious
Have you been to a dentist before? ☐ Yes ☐ No If so, when was your last dental visit: _____
How would you rate your previous dental experience? ☐ Excellent ☐ Good ☐ Average ☐ Poor
What are your dental concerns? _____
Have you avoided regular dental care? If so, why have you avoided regular dental care?
_____
Are you happy with the appearance of your teeth? ☐ Yes ☐ No
If not, why are you unhappy with the appearance of your teeth?_____
How often do you brush?_____ How often do you floss? _____
Would you like your teeth to be whiter? ☐ Yes ☐ No
Would you like your teeth to be straighter? ☐ Yes ☐ No

Do you have, or have you ever had any of the following dental conditions? Please check all that apply

☐ Aching or sensitive teeth	☐ Active decay of teeth or gums	☐ Areas of food traps
☐ Bad Breath	☐ Broken filling	☐ Broken or missing teeth Cold
☐ Cavities	☐ Clicking or popping jaw	☐ Sores
☐ Difficulty opening wide	☐ Dry mouth	☐ Aesthetic concerns with teeth
☐ Facial surgery	☐ Gag easily	☐ Gun Infection/ Disease Loose
☐ Growths or lesions in your mouth	☐ Jaw Clenching	☐ Teeth
☐ Nightguard	☐ Oral Surgery	☐ Orthodontic Treatment
☐ Sensitive or bleeding gums	☐ Swelling or lumps in mouth	☐ Swollen glands
☐ Teeth grinding	☐ Unfavorable dental experience	☐ None of the above

Previous Dentist or Dental Office
Name: _____ City: _____ State:_____

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Medical History

Are you currently being treated by a physician for a specific condition? ☐ Yes ☐ No
If so, please tell us about your treatment. _____
Have you recently been hospitalized or had a major operation? ☐ Yes ☐ No
If so, please tell us about the hospitalization. _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If so, please tell us about the head/neck injury._____

Are you taking any medications? ☐ Yes ☐ No
Please list all medications: _____

Are you on a special diet? ☐ Yes ☐ No
Please tell us about your diet: _____
Do you use tobacco? ☐ Yes ☐ No
Please tell us how often and what type of tobacco consumption:_____

Recreational drug and/or alcohol use, combined with local anesthesia may cause a life- threatening emergency.

Have you ever been advised that you require antibiotics prior to a dental appointment? ☐ Yes ☐ No
Please tell us about the antibiotics:_____

Do you take, or have you taken, PhenFen or Redux? ☐ Yes ☐ No
If so, please tell us about your PhenFen/Redux Usage:_____

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
If so, please tell us about your bisphosphonate usage:_____

Have you recently used controlled substances? ☐ Yes ☐ No
If so, please tell us which controlled substances and amount/frequency:_____

Have you recently consumed alcohol? ☐ Yes ☐ No
Please tell us how much alcohol and how recently:_____

Women (please check all that apply)

☐ Pregnant ☐ Trying to get pregnant ☐ Currently nursing ☐ Taking oral contraceptive ☐ None

Have you ever had an adverse reaction or allergies to any medication or substance? Please check if allergic

☐ Aspirin ☐ Acrylic ☐ Erythromycin ☐ Iodine
☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Novocaine
☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline ☐ Nitrous Oxide
☐ Valium ☐ Xylocaine
☐ None of the above
☐ If Other, please list: _____

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Do you have, or have you ever had any of the following medical conditions? Please Check all that apply

☐ Anemia	☐ Chemotherapy	☐ Cold Sores/ Fever Blisters	☐ Excessive Bleeding
☐ Frequent Cough	☐ Frequent Headaches	☐ Hay Fever	☐ Cortisone Medications
☐ Hemophilia	☐ High Blood Pressure	☐ Hives or Rash	☐ Kidney Problems
☐ Liver Disease	☐ Parathyroid Disease	☐ Recent Weight loss	☐ Rheumatism
☐ Shingles	☐ Spina Bifida	☐ Stroke	☐ Thyroid Disease
☐ Venereal Disease	☐ Arthritis or Gout	☐ Blood Disease	☐ Bruise Easily
☐ Diabetes	☐ Drug/Alcohol Addiction	☐ Emphysema	☐ Congenital Heart Problems
☐ Heart Murmur	☐ Frequent Urination	☐ Heart valve or Pacemaker	☐ Herpes
☐ Hypoglycemia	☐ Lung Disease	☐ Rheumatic Fever	☐ Tuberculosis
☐ Asthma	☐ Ulcers or GI Problems	☐ Chest Pains	☐ Convulsions
☐ Easily Winded	☐ Excessive Thirst	☐ Frequent Diarrhea	☐ Genital Herpes
☐ Hepatitis (B or C)	☐ Low Blood Pressure	☐ Irregular Heartbeat	☐ Heart Attack/ Heart Failure
☐ Leukemia	☐ Mitral Valve Prolapse	☐ Radiation Treatments	☐ Renal Disease
☐ Scarlet Fever	☐ Sickle Cell Disease	☐ Swelling of Limbs	☐ Stomach/Intestinal Disease
☐ Tonsillitis	☐ Yellow Jaundice	☐ Artificial Joint	☐ Blood Transfusion
☐ Cancer	☐ Dizziness or Fainting	☐ Eating Disorder	☐ Epilepsy or Seizures
☐ Glaucoma	☐ Heart Trouble	☐ Hepatitis A	☐ HIV-AIDS-ARC
☐ Jaw Joint Pain	☐ Psychiatric Care	☐ Sinus Problems	☐ Tumor or Growth
☐ X-ray/chemotherapy			
☐ No to All			

Do you have any condition or problem, not listed, which we should know about? Please Explain

_____

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 Date