DreamSmileDental
HIGH TECH COSMETIC DENTISTRY, P.C.

# PATIENT GET AQUAINTED AND MEDICAL HISTORY FORM

**PAYMENT IS EXPECTED AT TIME OF VISIT**

**PATIENT**:____________________________________________(________________________) Date:________________________
Last Name First Name Initial Preferred Name

Street Address:_____________________________________City:______________________State:_______Zip:_______________

Social Security#________-_____-__________E-MailAddress:________________________Home Phone:(____)_____________

Cell phone:________________________________________Other contact phone: _______________________________________

Sex: [ ] M [ ] F Age:_______ Birthdate:_____/_____/_____ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Employed by:___________________________________________________Occupation:_________________________________

Business Address:_____________________________________________________Business Phone:______________________

How do you prefer to be confirmed? [ ] Home Phone [ ] Cell Phone [ ] E-mail [ ] Work Phone [ ] Post Card (hygiene only)

Do we have permission to leave a message on your home phone regarding your appointment? [ ] Yes [ ] No

In case of emergency, who should be notified?_______________________________________Phone:_______________________

Whom may we thank for referring you?____________________________________________________________

**SPOUSE** Name:_____________________________Spouse Birthdate:____/____/____Spouse Employed by:_________________

Soc.Sec #:________________________Business Address:_______________________________Business Phone:_____________

**ACCOUNT INFORMATION -** Who will be responsible _________________________Relationship to Patient__________________

Dental Benefits Company:____________________________________________________Group #_________________________

Secondary Dental Benefits Company (if applicable):___________________________________Group #______________________

Insured Employee:__________________________________ Employee's Social Security #_________-_________-____________

**MEDICAL HISTORY -** Have you ever had any of the following? (check the boxes that apply)

| | | | |
|---|---|---|---|
| [ ] Heart Problems | [ ] Back Problems | [ ] Chronic Diarrhea | [ ] Sinus Problems |
| [ ] High Blood Pressure | [ ] Diabetes | [ ] Allergies to Anesthetics | [ ] Respiratory Disease |
| [ ] Low Blood Pressure | [ ] "AIDS" /other immune disorders | [ ] Blood Disease | [ ] Latex Allergy |
| [ ] Circulatory Problems | [ ] Epilepsy | [ ] Arthritis | [ ] Special Diet |
| [ ] Nervous Problems | [ ] Headaches | [ ] General Allergies | [ ] Stroke |
| [ ] Heart Murmur | [ ] Hepatitis | [ ] Allergies to Medicine/Drug | [ ] Ulcer |
| [ ] Artificial Heart Valves | [ ] Jaundice/Liver Disease | [ ] Radiation Treatment | [ ] Venereal Disease |
| [ ] Artificial Joints | [ ] Cancer | [ ] Swollen Neck Glands | [ ] Chemical Dependency |
| [ ] Recent Weight Loss | [ ] Psychiatric Care | [ ] Rheumatic Fever | [ ] Hemophilia |
| [ ] Autism/Aspergers | | | |

| | | |
|---|---|---|
| Have you ever had an adverse reaction to any medication? | [ ] Yes | [ ] No |
| Are you currently taking any medications? | [ ] Yes | [ ] No |
| Do you use tobacco products? | [ ] Yes | [ ] No |
| Are you under the care of a physician? | [ ] Yes | [ ] No |
| Is there anything else we should know about your medical history? | [ ] Yes | [ ] No |

If you answered "Yes" to any of the above questions please explain:__________________________________________________

Name of Physician: ________________________________________ Office Phone: ___________________________________

Address: _____________________________________________________________________________________________

**Women:** Do you suspect that you are pregnant? [ ] Yes [ ] No Are you nursing? [ ] Yes [ ] No

**DENTAL HISTORY :** Why did you leave your last dentist?

______________________________________________________________________

______________________________________________________________________

Are your teeth sensitive to: □Heat? [ ] Cold? [ ] Sweets? [ ] Biting Pressure?

Have you ever had an adverse reaction to any dental treatment? [ ] Yes [ ] No

Does food constantly get stuck between certain teeth in your mouth? [ ] Yes [ ] No

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? [ ] Yes [ ] No

Are you dissatisfied with your teeth in any way? [ ] Yes [ ] No

Has bad breath ever been a concern to you? [ ] Yes [ ] No

Do you snore? [ ] Yes [ ] No

Have you ever been diagnosed with Sleep Apnea? [ ] Yes [ ] No

Are you dissatisfied with the way your teeth look? [ ] Yes [ ] No
For example: ☐color, ☐shape
Other issues: ______________________________________________________________________

______________________________________________________________________

Do you have any fillings that show in your front teeth? [ ] Yes [ ] No

Do any of your fillings show when you smile? [ ] Yes [ ] No

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? [ ] Yes [ ] No

Have you ever had any teeth removed? [ ] Yes [ ] No

How long have these teeth been missing? ______________

Do your gums bleed when brushing? [ ] Yes [ ] No

Do you avoid any part of the mouth while brushing? [ ] Yes [ ] No

Have you been instructed regarding proper home care? [ ] Yes [ ] No

Have you ever considered whitening your teeth? [ ] Yes [ ] No

Would you like more information on whitening techniques? [ ] Yes [ ] No

Rate your smile on a scale of 1-10 1 2 3 4 5 6 7 8 9 10

If there were anything you could change about your smile, what would it be?______________________________

Is there anything else you would like to share about your dental history? ______________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature:________________________________________________Date:______________________

In order to provide you with better diagnosis and treatment Dream Smile Dental is sometimes required to take intra-oral images. I do hereby grant Dream Smile Dental permission to use my “before and after” photo and/or video (if applicable) for internal and educational use only. I understand my name will not appear in any materials used for educational purposes.

Signature:________________________________________________Date:______________________