Patient Information

Welcome

Patient Name: ______________________ **Date:** ____________
First Last

Patient Information

Street Address ______________________
City/State ______________ Zip Code __________ Home phone __________
Work phone ______________ Date of Birth __________ SS# __________
If patient is a full-time student, name of school ______________________
Employer ______________________ Address ______________________
______________ City/State ______________________ Zip Code ________
In case of emergency, who should be notified? ______________ Phone __________
Relationship to patient ______________ Driver's License State & Number ______________
Whom may we thank for referring you? ______________________

Primary Insurance

Primary Insurance

Policy Holder ______________________
Relation to Patient ______________________ Date of Birth ______________
Address (if different than patient) ______________________ City ______________
State ________ Zip Code __________ Policy Holder employed by ______________________
Address ______________________ City/State ______________________ Zip ________
SS# ______________ Work Phone ______________________
Insurance Company ______________________ Group Number ____ ______________
Subscriber # ______________________
Insurance Company Address ______________________ City/State ______________
Zip Code ________ Phone ______________

Secondary Insurance

Additional (Secondary) Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No
Policy Holder ______________________
Relation to Patient ______________________ Date of Birth ______________
Address (if different than patient) ______________________
City/State ______________________ Zip Code ______________
Policy Holder employed by ______________________
Address ______________________ City/State ______________ Zip Code ________
SS# ______________________ Work Phone ______________________
Insurance Company ______________________ Group Number ______________
Subscriber # ______________ Insurance Company Address ______________________
City, State ______________________ Zip Code __________ Phone ______________

Change in Insurance

Insurance Coverage Change **– Primary change___ Secondary change___ (please check)**

Date ______________ Policy Holder ______________________
Relation to Patient ______________________ Date of Birth ______________
Address (if different than patient) ______________________
City ______________ ______________ State ________ Zip Code ______________
Policy Holder employed by ______________________
Address ______________________ City/State ______________________ Zip Code ________
SS# ______________ Work Phone ______________________
Insurance Company ______________________ Group Number ______________
Subscriber # ______________________
Insurance Company Address ______________________ City/State ______________
Zip Code ______________ Phone ______________

____

Signature - Person Responsible for Account Date

ADA. Health History Form

Medical Alert	Condition	Premedication	Allergies	Anaest.	Date

Name ______ (Last / First / Middle) Home Phone ( ) ______ Business Phone ( ) ______

Address ______ (P.O. Box or Mailing address) City ______ State ______ Zip Code ______

Occupation ______ Height ______ Weight ______ Date of Birth __/__/__ Sex ☐ M ☐ F

SS# ______ Emergency Contact ______ Relationship ______ Phone ( ) ______

If you are completing this form for another person, what is your relationship to that person? ______ (Name / Relationship)

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain ______

How would you describe your current dental problem? ______

Date of your last dental exam ______ Date of last dental x-rays ______

What was done at that time? ______

How do you feel about the appearance of your teeth? ______

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

Yes	No	Don't Know	
☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? ______ Date of last physical examination ______

Physician(s) ______ NAME / PHONE / ADDRESS / CITY/STATE/ZIP

______ NAME / PHONE / ADDRESS / CITY/STATE/ZIP

Yes	No	Don't Know	
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? ______
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? Prescribed ______ Over the counter ______ Natural or herbal preparations ______
☐	☐	☐	Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ______ In the past month? ______ If yes, ______# of drinks per day for ______# of years
☐	☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list ______ Frequency of use (daily, weekly, etc.) ______ Number of years of recreational drug use ______
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not interested
☐	☐	☐	Do you wear contact lenses?

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know	
☐	☐	☐	Local anesthetics
☐	☐	☐	Aspirin
☐	☐	☐	Penicillin or other antibiotics
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Sulfa drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Latex
☐	☐	☐	Iodine
☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Animals
☐	☐	☐	Food (Specify) ______
☐	☐	☐	Other (Specify) ______

To yes responses, specify type of reaction ______

Yes	No	Don't Know	
(Women Only)			
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills?
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? ____________
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?

Name of physician or dentist* ______________________ Phone ____________

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopaedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will be glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (X) if you have or had any of the following diseases or problems.

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood transfusion If yes, date ____________
☐	☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	☐	Cardiovascular disease. If yes, specify below: ○ Angina ○ Arteriosclerosis ○ Artificial heart valves ○ Coronary insufficiency ○ Coronary occlusion ○ Damaged heart valves ○ Heart attack ○ Heart murmur ○ High blood pressure ○ Inborn heart defects ○ Mitral valve prolapse ○ Pacemaker ○ Rheumatic heart disease
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Chronic pain
☐	☐	☐	Persistent diarrhea
☐	☐	☐	Disease, drug, or radiation-induced immunosurpression
☐	☐	☐	Diabetes. If yes, specify below: ○ Type I (Insulin dependent) ○ Type II
☐	☐	☐	Dry mouth
☐	☐	☐	Eating disorder. If yes, specify ____________
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	G.E. reflux
☐	☐	☐	Glaucoma
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Recurrent infections Indicate type of infection ____________
☐	☐	☐	Kidney problems
☐	☐	☐	Low blood pressure
☐	☐	☐	Mental health disorders. If yes, specify below: ____________ ____________
☐	☐	☐	Malnutrition
☐	☐	☐	Migraines
☐	☐	☐	Night sweats
☐	☐	☐	Neurological disorders. If yes, specify ____________
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems. If yes, specify below: ○ Emphysema, ○ Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain: ____________ ____________ ____________

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____

Signature of Patient/Legal Guardian ____________ Date

For completion by dentist

Comments on patient interview concerning health history ______________________

____

____

Significant findings from questionnaire or oral interview ______________________

____

____

Dental management considerations ______________________

____

Signature of Dentist ____________ Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

LUMINEERS™ BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT...EVER!

Hold a mirror 12–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.

1 Do you like the appearance of your teeth; your smile? ❑ Yes ❑ No
If not, explain ______________________________
____

2 Are your teeth all in alignment (straight)? ❑ Yes ❑ No
If not, explain ______________________________
____

3 Do you have spaces that you don't like? ❑ Yes ❑ No
If yes, explain ______________________________
____

4 Do you like the color of your teeth? ❑ Yes ❑ No
If not, explain ______________________________
____

5 Do you like the shape of your teeth? ❑ Yes ❑ No
If not, explain ______________________________
____

6 Are your teeth...
chipped?__________ protruding?__________ hidden?__________
____

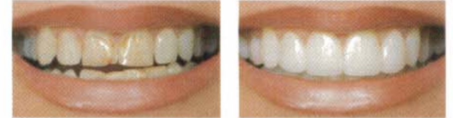
7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain ______________________________
____

8 Are there old fillings or dental work you don't like looking at? ❑ Yes ❑ No
If yes, explain ______________________________
____

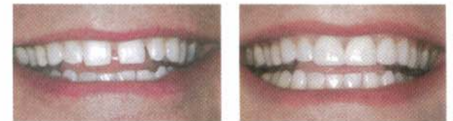
9 What would you like to change the most in the appearance of your teeth?
____
____

10 How would you like your teeth to look?
____
____
____

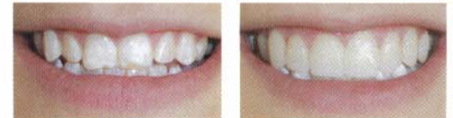
These smiles were achieved painlessly!



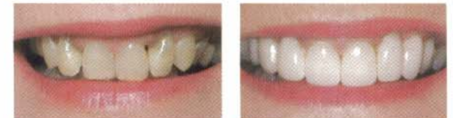
STAINED AND CHIPPED



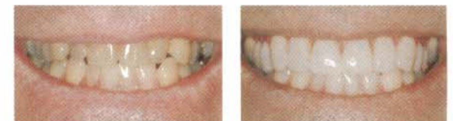
SPACES



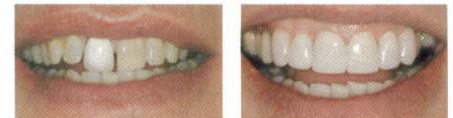
CALCIFICATION STAINS



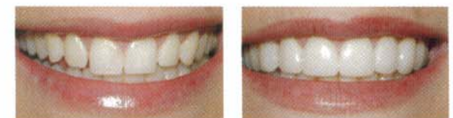
FANGED TEETH



STAINED AND CROOKED TEETH



PORCELAIN CROWNS



BEAUTIFUL SMILE

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