Welcome

Patient Information

Patient Name: _____ **Date:** _____

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 _____

ADA.

_____

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		Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	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.**

☐ ☐ ☐ 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)

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

To yes responses, specify type of reaction _____

Please complete both sides

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?_____

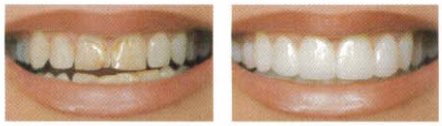
7 Are your teeth wearing on the biting surfaces? ❑ Yes ❑ No
If yes, explain _____

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?
_____

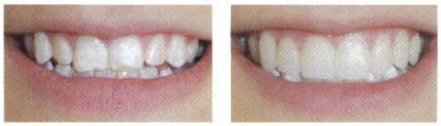
10 How would you like your teeth to look?
_____

These smiles were achieved painlessly!

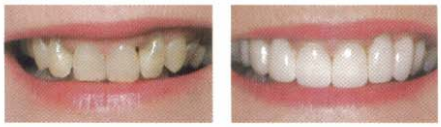


Stained and Chipped

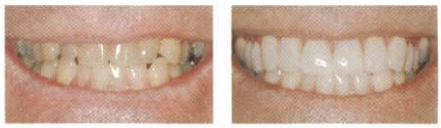
Spaces



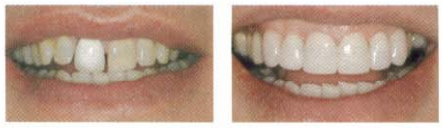
Calcification Stains



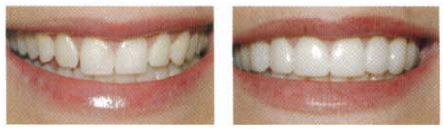
Fanged Teeth



Stained and Crooked Teeth



Porcelain Crowns



Beautiful Smile

YOUR SMILE IS THE EASIEST WAY TO IMPROVE YOUR APPEARANCE!

LUMINEERS™
BY CERINATE®
cerinate.com

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