one dental studio

WELCOME

The benefits of a happy, healthy are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

The better we communicate, the better we can care for you.

ABOUT YOU

Name_____

Preferred Name_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Other

Birthdate___/___/____Age_____SS# ---------- _____

Address_____

City_____State_____Zip_____

Email_____

Home#_____Work#_____

Mobile#_____Fax#_____

Whom may we thank for referring you?_____

Other family members seen by us _____

_____

Employer _____

Employer Address _____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT?

Name_____Relation_____

Mobile #_____Other # _____

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

(if under 18)

Name_____

Relation_____

Home#_____Work#_____

Mobile#_____Fax#_____

Email_____

Billing Address _____

City_____State_____Zip _____

DENTAL INSURANCE

Provider Name _____

Provider Address _____

City_____State _____ Zip _____

Group#_____

Insured's Name_____Relation_____

Insured's Birthdate_____Insured's ID# _____

Insured's Employer_____

SECONDARY INSURANCE

Provider Name _____

Provider Address _____

City_____State _____ Zip _____

Group#_____

Insured's Name_____Relation_____

Insured's Birthdate_____Insured's ID# _____

Insured's Employer_____

DENTAL

Has your doctor told you that you require antibiotics before dental treatment? ☐ YES ☐ NO

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ YES ☐ NO

Do you like your smile? ☐ YES ☐ NO

Do your gums bleed? ☐ YES ☐ NO

How many times a week do you clean between your teeth?_____ ☐ Floss ☐ Waterpik ☐ Other

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have questions at any time, please ask us. We are happy to help.
Our office is HIPPA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Do you ☐ Smoke ☐ Chew Tobacco ☐ Vape How Long?____

Are you currently taking any prescription/over the counter or supplemental drugs? ☐ YES ☐ NO

Please list each one _____

_____

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

Abnormal Bleeding
Alcohol/Drug Abuse
Anemia
Arthritis
Artificial Bones, Joints, or Valve
Asthma
Blood Transfusion
Cancer/Chemotherapy
Colitis
Congenital Heart Defect
Diabetes
Difficulty Breathing
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack
Heart Murmur
Heart Surgery
Hepatitis A/B/C
Hemophilia
Hepes/Fever Blisters
High Blood Pressue
HIV+/AIDS
Hospititalized for any reason
Kidney Problems
Liver Disease
Low Blood Pressue
Lupus
Mitral Valve Prolapse
Pacemaker
Psychiatric Problems
Radiation Treatment
Rheymati/Scarlet Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Sleep Disorder
Stroke
Thyroid Problems
Tuberculosis
Ulcers

Please list any medical condition(s) that you have ever had:_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin
Dental Anesthetics
Latex
Jewelry/Metal
Other
Codeine
Penicillin
Erthromycin
Tetracycline

Please list any other drugs or materials that you are or may be allergic to: _____

_____

FOR WOMEN ONLY

Are you taking birth control pills? □ YES □ NO
Are you pregnant □ YES □ NO Weeks?_____
Are you nursing? □ YES □ NO

QUESTIONNAIRE

Please check any of the following problems that apply to you:

☐ Sensitivity(hot, cold or sweet)
☐ Headaches/Earaches/Neck Pain
☐ Teeth or Fillings Breaking
☐ Grinding or Clenching Teeth
☐ Bleeding, Irritated or Swollen Gums
☐ Loose or Shifting Teeth
☐ Bad Breath

Please share the following approximate dates:

Last dental cleaning?_____
Last oral cancer screening?_____
Your last complete x-rays?_____

Who was your previous dentist?_____
Why did you leave?_____

If you could change your smile, would you:
(Please check all that apply)

☐ Make your teeth whiter
☐ Make your teeth straighter
☐ Close spaces between teeth
☐ Replace black or metal fillings with tooth color fillings
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Replace old crowns/veneers that don't match
☐ Have a smile makeover

What are the most important things to you about your smile and your oral dental health? _____

_____

DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize this dental team to perform any dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE