Welcome to Smile Garden Dental Center.

Please fill out this form completely. Please print.

Name-First:________________ Middle:______________ Last:______________ Mr. Mrs. Dr. Ms Miss

Nickname: ________________ Birthdate:______________ SS #: ______________

Address: ________________ City: ______________ State:________ Zip Code: __________

Home Phone:________________ Work Phone:______________ Cell Phone:______________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell E-mail ______________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered

Patient Employer:________________________ Occupation:______________

Person to contact in case of emergency: ______________ Phone: __________ Relationship: __________

Whom may we thank for referring you to us? ________________________

Primary Dental Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________

Ins. Co. Address:______________

____

Ins. Co. Phone: (_____) ______________

Member ID #:______________

Policy Owner's Name: ______________

Relationship to Patient:______________

Policy Owner's Birthdate: __/__/__ Group #: ______

Policy Owner's Employer:______________

Secondary Dental Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________

Ins. Co. Address:______________

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Ins. Co. Phone: (_____) ______________

Member ID #:______________

Policy Owner's Name: ______________

Relationship to Patient: ______________

Policy Owner's Birthdate: __/__/__ Group #: ______

Policy Owner's Employer: ______________

Dental Health

Previous Dentist:________________________ Phone:______________

Date of Last Visit: __________ Date of Last X-Ray: __________ Nature of Last Visit:______________

1. Are you having dental problems at this time?........ ☐ Yes ☐ No
   Explain: ________________________
2. Do you like the way your teeth look?........ ☐ Yes ☐ No
   Explain: ________________________
3. Do you like the size and shape of your teeth?........ ☐ Yes ☐ No
   Explain:________________________
4. Would you like your teeth to be whiter?........ ☐ Yes ☐ No
5. Do you have missing teeth that you would like to replace?........ ☐ Yes ☐ No
6. Do you have old silver fillings that you would like to replace with tooth colored fillings?........ ☐ Yes ☐ No
7. Do you feel very nervous about having dental treatment?........ ☐ Yes ☐ No
8. Have you ever had a bad experience in the dental office?........ ☐ Yes ☐ No
   Explain:________________________
9. If you could change anything about your smile, what would you change? ______________

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Please circle if you have ever had or are presently experiencing:

Blisters / Ulcers on lips or mouth

Surgery / Radiation to head or neck

Periodontal (Gum) treatment

Orthodontic (Braces) treatment

Endodontic (Root Canal) treatment

Crowns, Dentures, Implants, Bridges

Bleeding gums

Pain in your jaw joint

Locking of your jaws

Sensitivity to hot / cold

Sensitivity to biting

Clench or grind your teeth

Daily bad breath

Daily bad taste

Food impaction

Sensitivity to sweets

Clicking or popping of your jaws

Medical History

Name of Physician: ______________________ Phone: ______________

Date of Last Visit: ____________ Reason for visit: ______________________

Are you currently under physician's care? ____________ Please describe: ______________

____

PLEASE LIST ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS YOU ARE PRESENTLY TAKING:

____

____

Do you smoke? ____________ How much? ____________ For how long? ____________

Women: Are you pregnant? ____________ Nursing? ____________ Taking birth control pills? ____________

Have you ever taken or are you currently taking any medications for osteoporosis (Bisphosphonate)? ____________

Please check "Yes" or "No" to indicate if you have ever had or are presently experiencing

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Attack/Stroke	☐ Yes	☐ No	Severe/Frequent Headaches	☐ Yes	☐ No	Anorexia/Bulimia	☐ Yes	☐ No
Heart Surgery/Pacemaker	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Head/Neck Trauma	☐ Yes	☐ No	Colitis	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Asthma/Emphysema	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Drug/Alcohol Abuse	☐ Yes	☐ No
Cancer/Chemo/Radiation	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No	HIV+/AIDS	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Liver/Kidney Problems	☐ Yes	☐ No	Back Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Shingles	☐ Yes	☐ No			

Please list other medical conditions or hospitalizations: ______________________

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____

Are you allergic to any of the following? (Please circle)

Penicillin	Codeine	Erythromycin	Latex
Tetracycline	Dental Anesthetics	Iodine	Aspirin

Please list other allergies you may have: ______________________

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The information I have given is to the best of my knowledge. I understand this information will be held in strictest confidence. I authorize Smile Garden Dental Center to perform any necessary dental services with my informed consent.

Signature: ______________________ Date: ______________

Notes: ____

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