Aesthetic Dentistry of Palm City

"Commitment to Excellence"

Welcome

Thank you for selecting our exceptional dental healthcare team. Our primary commitment is to provide our patients with the best possible dental care. To help us meet your dental health care needs, please fill out this form in ink. If you have any questions or need assistance please ask.

Date_____ Social Security #_____ Email _____ Cell _____

Patient Information (Confidential)

Name_____ Birthdate_____ Phone_____

Address_____ City_____ State____ Zip _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College_____ City_____ State____ ☐ Full time ☐ Part-time

Patient's or Parent's Employer_____ Work Phone _____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Person Responsible for this Account_____ Relationship to Patient _____

Address_____ Phone_____

Driver's License #_____ Birthdate_____ Financial Institution _____

Employer_____ Work Phone_____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Patient Medical History

Physician_____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, Please explain. ☐ Yes ☐ No

_____

Are you taking any medication(s) including nonprescription medicine? If yes, what are you taking? _____ ☐ Yes ☐ No

Are you currently taking pre-medication for dental procedures or have you been advised in the past to take pre-medication prior to dental treatment? If Yes, Please explain: ☐ Yes ☐ No

_____

Have you ever taken Fosamax, Actonel or Boniva? ☐ Yes ☐ No

Have you ever received intravenously Aredia or Zometa? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to:

Local Anesthetics (eg. novocaine)	☐ Yes	☐ No
Penicillin or any other antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Barbituates	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any Metals (eg. nickel, mercury, etc.)	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No
Other (Please list)	☐ Yes	☐ No

_____

Women Only:

Are you pregnant or think you may be?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking contraceptives?	☐ Yes	☐ No

Do you have or have you had:

Heart Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	AIDS or HIV Infection	☐ Yes ☐ No
Heart Murmer	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Sexually Transmitted Dis.	☐ Yes ☐ No
MVP	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No	_____	
Heart Attack	☐ Yes ☐ No	Chemo Therapy	☐ Yes ☐ No	Do you take dietary	
Chest Pains/Angina	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	supplements regularly?	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No		
Rheumatic Fever	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Do you regularly take any	
Pacemaker	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	of the following:	
Defibrillator	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No	Garlic	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Hay Fever/Allergies	☐ Yes ☐ No	Ginger	☐ Yes ☐ No
Stents	☐ Yes ☐ No	Epilepsy/Convulsions	☐ Yes ☐ No	Ginko	☐ Yes ☐ No
Ports_____	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No	Ginseng	☐ Yes ☐ No
Other_____	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Fish Oil	☐ Yes ☐ No
Valve Replacement	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Vitamin E	☐ Yes ☐ No
Filters	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Echinacea	☐ Yes ☐ No
Dental Implants	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	St. John's Wart	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Kava	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Valerian	☐ Yes ☐ No

Patient Dental History

Do your gums bleed while brushing/flossing?	☐ Yes	☐ No
Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
Are your teeth sensitive to sweet or sour?	☐ Yes	☐ No
Do you feel pain to any of your teeth?	☐ Yes	☐ No
Do you have sores or lumps in your mouth?	☐ Yes	☐ No
Have you had any head, neck or jaw injuries?	☐ Yes	☐ No
Have you experienced any of the following:		
Clicking	☐ Yes	☐ No
Pain (joint, ear, side of face)	☐ Yes	☐ No
Difficulty in opening or closing mouth	☐ Yes	☐ No

Do you have frequent headaches?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
Are you missing any teeth?	☐ Yes	☐ No
Have you had difficult extractions?	☐ Yes	☐ No
Have you had prolonged bleeding following extractions?	☐ Yes	☐ No
Have you had any orthodontic treatment?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
If yes, date of placement_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐ Yes	☐ No

Smile Evaluation

Do you like the way your teeth look? _____	☐ Yes	☐ No
Are you happy with the color of your teeth? _____	☐ Yes	☐ No
Would you like your teeth to be whiter? _____	☐ Yes	☐ No
Would you like your teeth to be straighter? _____	☐ Yes	☐ No
Do you have spaces between your teeth that you would like closed? _____	☐ Yes	☐ No
Would you like your teeth to be longer? _____	☐ Yes	☐ No
Do you like the shape of your teeth? _____	☐ Yes	☐ No
Do you have missing teeth that you would like to replace? _____	☐ Yes	☐ No
Do you have silver fillings that you would like to replace with _____ tooth colored fillings?	☐ Yes	☐ No
If you could Change anything about your smile, what would you change? _____	☐ Yes	☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental treatment to health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent)_____