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 healthcare 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 ____________________

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_________________________________

Birthdate______________ Employer_______________________________ Work Phone_________________

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

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Have you been advised to take **Pre-Medication** antibiotics prior to your dental treatment?
If Yes, list PRE-MED taken. ☐ Yes ☐ No

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

Are you taking Prolia or Forteo? ☐ 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 ☐ 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

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Women Only:

Are you pregnant or think you may be? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking contraceptives? ☐ Yes ☐ No

Are you taking any medication(s) including over the counter medications and supplements? ☐ Yes ☐ No

If Yes, List ____

Do you have or have you had:

Condition	Yes	No
Heart Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
MVP	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Chest Pains/Angina	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Defibrillator	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Stents	☐ Yes	☐ No
Valve Replacement	☐ Yes	☐ No
Filters	☐ Yes	☐ No
Dental Implants	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Chemo Therapy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Recent Weight Loss	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No
Hay Fever/Allergies	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hepatitis Type______	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No
Sexually Transmitted Dis.	☐ Yes	☐ No
Do you take dietary supplements regularly?	☐ Yes	☐ No

Do you regularly take any of the following:

Supplement	Yes	No
Garlic	☐ Yes	☐ No
Ginger	☐ Yes	☐ No
Ginko	☐ Yes	☐ No
Ginseng	☐ Yes	☐ No
Fish Oil	☐ Yes	☐ No
Vitamin E	☐ Yes	☐ No
Echinacea	☐ Yes	☐ No
St. John's Wart	☐ Yes	☐ No
Kava	☐ 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 in 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 ☐ Yes ☐ No
- Difficulty in chewing ☐ 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
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__________________

Smile/Cosmetic Evaluation

If you could Change anything about your smile, what would you change? (For Example: Color, Shape, Spacing, Straighter, Silver Fillings, Missing Teeth, etc.) ____________________

Have you had Botox/Dysport and/or Dermal Fillers (Juvederm, Restylane, Voluma, Radiesse) in the past? ☐ Yes ☐ No
Would you be interested? ☐ Yes ☐ No
What additional services would you like to learn about?
- ☐ Clenching/Grinding Treatments
- ☐ Straightening Crowded Teeth/Invisalign
- ☐ Correcting Facial Asymmetries
- ☐ Improving Thin Lips/Liplines
- ☐ Facial Injectables/Fillers
- ☐ Improvement of Facial Lines/Wrinkles
- ☐ Brow Lift
- ☐ Other ____________________

Snoring/Sleep Apnea

Do you snore more than three nights a week? ☐ Yes ☐ No
Is your snoring loud (can be heard through a door or wall)? ☐ Yes ☐ No
Has anyone ever told you that you briefly stop breathing or gasp when you are asleep? ☐ Yes ☐ No
Do you feel fatigued throughout the day? ☐ Yes ☐ No

Photo Release

I agree that Aesthetic Dentistry of Palm City, Inc. may use photographs of me, with or without my name, for example, such purposes as publicity, illustration, advertising and web content. I authorize the release of my photo(s). ☐ Yes ☐ No

Signature ______________________________ Date ____________________

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)____