welcome smiles

MEDICAL HISTORY

Patient Name:	**Date of Birth:**
Social Security Number:	**Employer:**
Address:	**Home Phone:** **Cell Phone:**
E-Mail Address:	**Work Phone:**

Please list any prescriptions you are currently taking:

_____

_____

_____

Please list any herbal medications/supplements you are currently taking:

_____

_____

_____

Please list any medical allergies you may have:

_____

_____

Physician's Name and Location:

_____

When was your last complete physical including blood tests? _____

Most Recent Visit to Physician and Reason:

_____

Do we have permission to consult with your physician? □Yes □No
Have you been hospitalized or had a serious illness within the last year? □Yes □No
Are you currently receiving **intravenous** Biphosphonates? □Yes □No
If Yes, for how long: _____
Are you currently taking **oral** Biphosphonates (Fosamax, Actonel, Boniva)? □Yes □No
If Yes, for how long: _____

Women Only: Are you currently pregnant? □Yes □No
If Yes, expected due date: _____
Are you currently nursing? □Yes □No

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Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Disease	Yes	No	Cold Sores/Fever Blisters	Yes	No	Headaches/Migraines	Yes	No
Congenital Heart Disease	Yes	No	Acid Reflux	Yes	No	Psychiatric Care	Yes	No
Heart Murmur	Yes	No	Tobacco Use	Yes	No	Neurological Disorders	Yes	No
High Blood Pressure	Yes	No	Ulcers	Yes	No	Seizures	Yes	No
Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No	Dizziness/Fainting	Yes	No
Pacemaker	Yes	No	Liver Disease	Yes	No	Nervous/Anxious	Yes	No
Rheumatic Fever	Yes	No	Sinus Problems	Yes	No	Epilepsy	Yes	No
Chest Pain	Yes	No	Asthma	Yes	No	Arthritis	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Artificial Joints	Yes	No
Stroke	Yes	No	Respiratory Problems	Yes	No	Autoimmune Disorder	Yes	No
Blood Disease	Yes	No	Sleep Apnea	Yes	No	Seasonal Allergies	Yes	No
Blood Thinners	Yes	No	Tuberculosis	Yes	No	Steroid Therapy	Yes	No
Hemophilia	Yes	No	Radiation Treatment	Yes	No	Diabetes	Yes	No
Hepatitis	Yes	No	Chemotherapy	Yes	No	Latex Allergy	Yes	No
HIV/AIDS	Yes	No	Glaucoma	Yes	No	Organ Transplant	Yes	No
Jaundice	Yes	No	Hearing Disorders	Yes	No	Novocaine Reaction	Yes	No
Sickle Cell Disease	Yes	No	Kidney Trouble	Yes	No	Epinephrine Reaction	Yes	No

If anything circled above needs further explanation, please describe:

_____

_____

_____

_____

Do you have or have you had any disease, condition, or problem not listed?

_____

_____

Patient/Guardian Signature: _____ Date: _____

History Review:

Dentist Signature_____Date_____

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Dental Information

Patient Name: _____

How would you rate the condition of your mouth? □Excellent □Good □Fair □Poor

Previous Dentist's name and how long you have been a patient there: _____

_____

Any contact information that you may have of your previous dental office: _____

_____

I routinely see my dentist every: □3 mo. □4 mo. □6 mo. □12 mo. □Not routinely

Do you have any immediate concerns? _____

Are you fearful of the dentist? Please circle on the scale: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Have you had an unfavorable dental experience?	□Yes	□No
Have you ever had trouble getting numb or had reactions to local anesthetic?	□Yes	□No
Have you ever been diagnosed or treated for periodontal (gum) disease?	□Yes	□No
Do your gums bleed when brushing, flossing, or eating?	□Yes	□No
Do you/would you have any problems chewing bagels or other hard foods?	□Yes	□No
Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking)	□Yes	□No
Do you wear or have you ever worn a bite appliance?	□Yes	□No
Are you aware of clenching your teeth during the day?	□Yes	□No
Has anyone ever told you that you grind or clench your teeth while you are asleep?	□Yes	□No
When you wake up have you noticed tension or fatigue in your facial muscles?	□Yes	□No
Has anyone ever told you that you snore loudly?	□Yes	□No
Do you have a dry mouth?	□Yes	□No
Have you had any cavities within the past 3 years?	□Yes	□No
Is there anything about the appearance of your teeth that you would like to change?	□Yes	□No
Have you ever whitened (bleached) your teeth?	□Yes	□No

Patient Signature: _____ **Doctor's Signature _____**

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Consent for Services and Financial Policy

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient/Guardian Signature: _____ Date: _____

Email and Text Correspondence

Our office offers text and email correspondence.
We invite you to participate in our online system!

Features include:

- Request Appointments Online
- Receive Text Message/Email Appointment Reminders
- Correspondence Regarding Your Dental Health
- Confirm Appointments via Email or Text

Would you like to opt in? Yes No

HIPAA Acknowledgement

I have the right to request a copy of this office's Notice of Privacy Practices at any point.

I give permission to Welcome Smiles to discuss my dental treatment with the following people/Parents/Guardian:

_____

_____

Patient/Guardian Signature: _____ Date: _____