

NAME \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
SEX \_\_\_\_\_  
MARITAL STATUS: \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_  
PHONE \_\_\_\_\_

YOUR EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_

NAME OF A PERSON NOT LIVING WITH YOU \_\_\_\_\_  
PHONE \_\_\_\_\_

REFERRED BY: \_\_\_\_\_  
\_\_\_\_\_

*E-Mail*

ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SPOUSE'S NAME \_\_\_\_\_  
SPOUSE'S EMPLOYER \_\_\_\_\_  
SPOUSE'S WORK PHONE \_\_\_\_\_  
SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

LAST PHYSICAL EXAM \_\_\_\_\_  
LAST DENTAL EXAM \_\_\_\_\_

YOUR INSURANCE COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_  
GROUP NAME \_\_\_\_\_  
PERSON TO CONTACT \_\_\_\_\_  
COVERAGE TYPE \_\_\_\_\_

In order to minimize bookkeeping costs, payment is required at time of treatment.

- PAYMENT BY CASH OR CHECK
- PAYMENT BY VISA OR MASTERCARD
- DENTAL INSURANCE - DEDUCTABLE AND CO PAYMENT REQUIRED AT TIME OF TREATMENT.

I authorize Dr Jeffrey Smith and delegates to perform the dental procedures advisable for myself/child including the use of local anesthetics and/or nitrous oxide analgesia.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

Thank you for completing the following  
confidential information.  
**PLEASE ANSWER ALL QUESTIONS.**  
*MEDICAL /DENTAL HISTORY*

**REASON FOR TODAY'S VISIT** \_\_\_\_\_

Please state whether you have suffered any of the following

YES NO

- RHEUMATIC FEVER
- HEART MURMUR
- CONGENITAL HEART DISORDER
- HEART SURGERY
- PROSTHETIC VALVES
- OTHER HEART CONDITON
- PENNICILLIN ALLERGY
- BLOOD TRANSFUSION, date \_\_\_\_\_
- ARE YOU ALLERGIC TO ANY MEDICATION NOT LISTED ABOVE? PLEASE LIST: \_\_\_\_\_

YES NO

- RESPIRATORY PROBLEMS
- KIDNEY DISEASE
- VENEREAL DISEASE
- AIDS
- HIGH BLOOD PRESSURE
- TUBERCULOSIS
- CODEINE ALLERGY

YES NO

- DIABETES
- SEIZURES
- MALIGNANCY
- HEPATITIS
- PREGNANT?
- ASPIRIN ALLERGY

- ARE YOU TAKING ANY MEDICATION AT THIS TIME? PLEASE LIST: \_\_\_\_\_

Please describe any symptoms.

- BLEEDING, SORE GUMS
- BURNING TONGUE, LIPS
- ORTHO TREATMENT (BRACES)
- BAD TASTE /BREATH
- FREQUENT BLISTERS
- BITING LIPS/CHEEKS
- LOOSE TEETH
- SWELLING/LUMPS
- FILLINGS

YES NO

- FOOD IMPACTION
- DIFFICULTY OPENING OR CLOSING JAW
- CLICKING/POPPING JAW
- ARE YOUR TEETH SENSITIVE TO HOT?
- ARE YOUR TEETH SENSITIVE TO COLD?
- ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH?
- DO YOU HAVE DISCOLORED TEETH THAT BOTHER YOU?
- WOULD YOU LIKE TO KNOW MORE ABOUT PERMANENT REPLACEMENT?
- ARE YOU INTERESTED IN TOOTH-COLORED FILLINGS?
- ARE YOU INTERESTED IN IMPLANTS?

YES NO

- CLENCHING /GRINDING
- PAIN IN OR AROUND EARS
- HAVE YOU LOST ANY TEETH?
- ARE YOUR TEETH SENSITIVE TO SWEETS
- ARE YOUR TEETH SENSITIVE TO BITING?

Do you use the following and how often?

- TOOTH BRUSH \_\_\_\_\_
- DENTAL FLOSS \_\_\_\_\_
- FLUORIDE RINSE \_\_\_\_\_

IS YOUR TOOTH BRUSH : SOFT  MEDIUM  HARD

## POLICIES REGARDING TREATMENT

### 1. APPOINTMENTS:

Appointment times are "reserved". This means that we do not "double book" our appointments. This is an advantage to you because it allows you to be seen at a specific time. We respect your time and we make a special effort to be on time.

### 2. CANCELLATIONS AND BROKEN APPOINTMENTS:

**24 hour notice is required when canceling or rescheduling an appointment.** If an appointment is canceled with less than 24 hour notice, a \$75 charge will be made. Failure to show for an appointment does not release the obligation for the time. We are understanding for unusual circumstances but chronic failure of appointments is not compatible to our type of practice where times are reserved.

### 3. CONFIRMATION OF APPOINTMENTS:

We will make every effort to reach our patients to remind them of their appointment. This is usually done the week before the appointment. Failure to reach an individual does not remove the financial obligation for the time. Scheduled appointments are the patient's responsibility.

### 4. INSURANCE:

If you have insurance, we will gladly process your forms, but we request that you pay your portion when services are rendered. Please have your portion of the forms filled out. If your insurance company has not paid after 30 days, you are responsible for any remaining balance.

### 5. PAST DUE BILLS:

If an account is past due for more than 60 days, a 1.5% per month finance charge will be added unless other arrangements have been made.

**I have read and understood the policies of this office.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

## Are You a Candidate For Cosmetic Dentistry?

*self-analysis:*

Why change your smile? Don't if you're happy with it, but ask yourself the following questions:

	Yes	No
1. Does your self-confidence lessen when smiling in front of other people?	_____	_____
2. Do you ever put your hand up to cover your smile?	_____	_____
3. Do you feel you photograph better from one side of your face?	_____	_____
4. Is there someone you think has a better smile than you?	_____	_____
5. Do you look at magazines and wish you had a smile as pretty as the model's?	_____	_____
6. When you read a fashion magazine, are your eyes drawn to the model's smile?	_____	_____
7. When you look at your smile in the mirror, do you see a minor defect in your gums or in any of your teeth?	_____	_____
8. Do you wish your teeth were whiter?	_____	_____
9. Do you wish your gums looked better?	_____	_____
10. Do you wish you showed more or fewer teeth when smiling?	_____	_____
11. Do you think you show too much or too little gum tissue when you smile?	_____	_____
12. Do you wish you had longer or shorter teeth?	_____	_____
13. Would you prefer wider or narrower teeth?	_____	_____
14. Are your teeth too square or too round?	_____	_____
15. Do you wish your teeth were shaped differently?	_____	_____

If you answered "NO" to every question except #1, #9 and #15, you are apparently content with your smile.

### TMD Screening Questionnaire

(Temporomandibular joint/jaw joint)

	Yes	No			Degree of Discomfort
					<i>mild-1-2-3-4-5-severe</i>
16.	_____	_____	Do you suffer from frequent headaches (e.g. more than once a week)?	_____	
17.	_____	_____	Do you ever have pain, discomfort, or other sensations (ringing, roaring, stuffiness, etc.), in front of or behind the ear?	_____	
18.	_____	_____	Do you ever have pain, discomfort, or other sensations (tiredness, pulling, weakness, burning, etc.) about the ears, temples, neck or cheek?	_____	
19.	_____	_____	Does it ever hurt to chew or is your bite ever uncomfortable or unusual?	_____	
20.	_____	_____	Does it ever hurt to open wide, take a big bite or yawn?	_____	
21.	_____	_____	Does your jaw ever make noise (popping, cracking, grating, etc.) or does your jaw ever lock?	_____	
22.	_____	_____	Have you had any serious trouble associated with any previous dental treatment? If so, explain.	_____	
23.	_____	_____	Have you ever had an injury to your head, neck or jaw (e.g. due to an auto accident)?	_____	
24.	_____	_____	Have you previously been treated for jaw or joint problems? If so, when? _____	_____	
25.	_____	_____	Are you wearing removable dental appliances (e.g. bite plane, retainer, nightguard, etc.)?	_____	

Chief Dental Complaint? \_\_\_\_\_

Dental management considerations: \_\_\_\_\_