

Elegant Smile Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name: _____ SS#: _____
 Last First Initial

Address: _____
 Street City Zip

Home No: _____ Cell. No: _____ Office No: _____

Birth date: _____ Male/Female: _____ Email Address: _____

Marital Status: _____ Age: _____ Drivers License/CAL ID: _____

Employer: _____ Occupation/ Position: _____

Office Address: _____

Person to contact in Case of an Emergency: _____ Phone No: _____

Whom May We Thank for Referring You? _____
 Another Patient _____ Advertisement _____ Friend _____ Other _____

PRIMARY INSURANCE

Name of Insurance Plan: _____ Group No: _____

Person Responsible for Account: _____ SS#: _____

Relation to Patient: _____ Birth date: _____

Insured's Employer: _____ Bus. Phone No: _____

Do you have Secondary Insurance? _____ Name of Insurance Plan: _____

Name of Former Dentist: _____ Phone No: _____

Date of Last Dental Care: _____ Date of Last X-Rays: _____

How often do you brush? _____ Floss: _____

How may we serve you today? _____

How do you feel about the appearance of your teeth?: _____

KINDLY CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad Breath	<input type="checkbox"/>	Food Collection Between Teeth	<input type="checkbox"/>	Periodontal Treatment	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	Grinding/Clenching Teeth	<input type="checkbox"/>	Sensitivity To Hot/Cold	<input type="checkbox"/>
Clicking/Popping Jaw	<input type="checkbox"/>	Loose Teeth or Broken Fillings	<input type="checkbox"/>	Sores/Growths in Mouth	<input type="checkbox"/>
Amalgam Fillings	<input type="checkbox"/>	Migraines/Headaches	<input type="checkbox"/>	Snoring/Sleep Apnea	<input type="checkbox"/>
Sports Activities	<input type="checkbox"/>	Sports Guard	<input type="checkbox"/>	Teeth Whitening	<input type="checkbox"/>

MEDICAL HISTORY

Are you currently under a physician's care? _____ for what condition: _____

Dr.'s Name: _____ Dr.'s Phone No. _____

Have you had any serious illness or operation? _____ if yes, please describe: _____

Have you ever had a blood transfusion? _____ If yes, approximately when? _____

For women: Are you pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Rheumatic Fever	Y	N	Heart Problem	Y	N	Heart Murmur	Y	N
Pacemaker/Heart Surgery	Y	N	Artificial Heart Valves	Y	N	Shortness of Breath	Y	N
Surgical Implants	Y	N	Low Blood Pressure	Y	N	High Blood Pressure	Y	N
Stroke	Y	N	Fainting/Dizziness	Y	N	Headaches	Y	N
Epilepsy	Y	N	Kidney Disease/Malfunction	Y	N	Swelling of the Feet/Ankle	Y	N
Persistent Cough	Y	N	Tuberculosis	Y	N	Sinus Problem	Y	N
Cough Up Blood	Y	N	Respiratory Disease	Y	N	Tobacco Habit	Y	N
Blood Disease	Y	N	Liver Disease	Y	N	Hepatitis	Y	N
Anemia	Y	N	Cancer	Y	N	Radiation Therapy	Y	N
Chemotherapy	Y	N	Diabetes	Y	N	Parathyroid Disease	Y	N
Thyroid Disease	Y	N	Stomach Ulcers/Colitis	Y	N	Skin Rash	Y	N
Food Allergies	Y	N	Anaphylaxis	Y	N	Metallic Allergies	Y	N
Back Problems	Y	N	Nervous Problems	Y	N	Psychiatric Care	Y	N
AIDS/HIV Positive	Y	N	Herpes/Genital Herpes	Y	N	Veneral Disease	Y	N
Cortisone Treatment	Y	N	Rapid Weight Gain/Loss	Y	N	Glaucoma	Y	N
Arthritis	Y	N	PHEN-FEN	Y	N	Latex Sensitivity	Y	N

List Any Medications You Are Currently Taking:

Allergies, If Any:

AUTHORIZATION

I have reviewed the information on this questioner, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorize the dentist to release all information necessary to secure the payment whether or not paid by insurance. I understand that I am responsible for all charges incurred whether or not paid by insurance.

Signature

Date

Doctor's Signature

Date

I HAVE READ THE COPY PROVIDED OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

Signature

Date

Elegant Smile Dental

BEHAVIORAL/TREATMENT PLANNING CONSULTATION FORM

WE REALIZE THAT MANY PEOPLE ARE NERVOUS OR FRIGHTENED ABOUT GOING TO THE DENTIST. IF YOU HAVE SUCH FEELINGS WE WOULD LIKE TO HELP YOU. PLEASE ANSWER THESE QUESTIONS CAREFULLY. THIS INFORMATION WILL MAKE YOUR DENTAL EXPERIENCE MORE COMFORTABLE. PLEASE CHECK THE ANSWER THAT BEST DESCRIBES YOUR FEELINGS. THANK YOU FOR YOUR COOPERATION.

1. IF YOU HAD TO GO TO THE DENTIST TOMORROW, HOW WOULD YOU FEEL ABOUT IT?
 I WOULD LOOK FORWARD TO IT AS A REASONABLY ENJOYABLE EXPERIENCE.
 I WOULDN'T CARE ONE WAY OR THE OTHER.
 I WOULD BE A LITTLE UNEASY ABOUT IT.
 I WOULD BE AFRAID THAT IT WOULD BE UNPLEASANT AND PAINFUL.
 I WOULD BE VERY FRIGHTENED OF WHAT THE DENTIST MIGHT DO.

2. WHEN YOU ARE WAITING IN THE DENTAL OFFICE FOR YOUR TURN IN THE CHAIR, HOW DO YOU FEEL?
 RELAXED
 TENSE
 A LITTLE UNEASY
 ANXIOUS
 SO ANXIOUS THAT I SOMETIMES BREAK OUT IN A SWEAT OR ALMOST FEEL PHYSICALLY SICK.

3. WHEN YOU ARE IN THE DENTIST'S CHAIR WAITING WHILE HE GETS HIS INSTRUMENTS READY TO BEGIN WORKING ON YOUR TEETH, HOW DO YOU FEEL?
 RELAXED
 TENSE
 A LITTLE UNEASY
 ANXIOUS
 SO ANXIOUS THAT I SOMETIMES BREAK OUT IN A SWEAT OR ALMOST FEEL PHYSICALLY SICK.

4. YOU ARE IN THE DENTIST'S CHAIR TO HAVE YOUR TEETH CLEANED. WHILE YOU ARE WAITING AND THE DENTIST IS GETTING OUT THE INSTRUMENTS, WHICH HE WILL USE TO CLEAN YOUR TEETH AROUND THE GUMS, HOW DO YOU FEEL?
 RELAXED
 TENSE
 A LITTLE UNEASY
 ANXIOUS
 SO ANXIOUS THAT I SOMETIMES BREAK OUT IN A SWEAT OR ALMOST FEEL PHYSICALLY SICK.

5. HAVE YOU EVER BEEN TENSE OR NERVOUS ABOUT YOUR DENTAL THERAPY? ___YES___NO

6. HAS LOCAL ANESTHETIC EVER FAILED TO WORK FOR YOU? ___YES___NO

7. HAVE YOU TRIED NITROUS OXIDE (LAUGHING GAS)?___YES___NO

8. WAS NITROUS OXIDE SUFFICIENT TO ALLEVIATE YOUR ANXIETY?___YES___NO

9. HAVE YOU EVER HAD INTRAVENOUS SEDATION OR GENERAL ANESTHESIA IN A DENTAL OFFICE?___YES___NO

10. WAS SEDATION SUFFICIENT TO ALLEVIATE YOUR PAIN?___YES___NO

11. WOULD YOU LIKE A CONSULTATION WITH OUR DENTIST TO DISCUSS SPECIFIC WAYS TO ALLEVIATE PAIN ANXIETY FOR ALL FORMS OF DENTAL THERAPY?___YES___NO