



"Taking Your Smile in the Right Direction"

Patient Information

Preferred Name:

Name: Married Single Minor Male Female

Address: City: State: Zip:

Birth Date: SSN:

Contact Numbers: (check where you would prefer we call or contact you.)

Daytime Phone: Email:

Evening Phone: Cell Phone:

Place of Employment or School?

Whom may we thank for referring you to our office?

Medical History: (Check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Clindamycin Allergy |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy - Due Date- | <input type="checkbox"/> Erythromycin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Novocaine/Lidocaine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Epinephrine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other: <input type="text"/> |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Snoring | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Cardiac Transplant | <input type="checkbox"/> Hepatitis A,B,C | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Congenital Heart Condition | <input type="checkbox"/> History of Infective Endocarditis | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Codeine Allergy | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Amoxicillin Allergy | |

Are you under a physicians care? Why? Yes No

Are you taking any medications? What? Yes No

Are you allergic to any medications? What? Yes No

(Examples: Penicillin, Sulfa, Codeine, Latex, Metals, Acrylic)

Are you pregnant or trying? Contraceptives? Yes No

Have you had a serious accident or hospitalization? Yes No

Normal blood pressure if known?

Dental History

How healthy do you want us to get your mouth? Don't really care Average The best it can be

At what point do you want to initiate treatment? When my tooth hurts or breaks When something is worsening When something isn't ideal

What quality of dentistry do you want Dr. West to recommend? Just patch it Average Ideal, the best

What about your smile would you like to change?

If we could show you an easy and safe way to lighten your teeth, would you be interested? Yes No

Modern dentistry now allows us to invisibly straighten teeth! Does this interest you? Yes No

Do you have a specific dental problem?

Describe: Yes No

Do you have regular dental care? Last Visit? Yes No

Do you think you have decay, gum disease or jaw problems? Yes No

Do you floss? How often? Yes No

Do your gums ever bleed? Yes No

Does food catch between your teeth? Yes No

Do you have any loose teeth? Yes No

Do you ever have clicking, popping, or discomfort in your jaw joint? Yes No

Do you ever clench or grind your teeth? Yes No

Have you ever had a bad experience with a dentist? Yes No

Do you smoke or chew tobacco? Yes No

Name of previous dentist and location: (optional)

Last date of X-Rays: Bite Wings: Panorex: Full Series:

Symptoms: (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> TMJ Pain | <input type="checkbox"/> Tender Sensitive Teeth |
| <input type="checkbox"/> TMJ Noise | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Limited Opening | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Ear Congestion | <input type="checkbox"/> Postural Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling In Fingers |
| <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Hot & Cold Sensitivity |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Clenching/Bruxing | <input type="checkbox"/> Trigeminal Neuralgia |
| <input type="checkbox"/> Bells Palsy | <input type="checkbox"/> Back Pain |

Family Information

Father (or Husband)

First Name M. Last Name

Street

City State Zip

Home Phone Work Phone

Birth Date Social Security #

Mother (or Wife)

First Name M. Last Name

Street

City State Zip

Home Phone Work Phone

Birth Date Social Security #

IN CASE OF EMERGENCY

Outside of immediate household or family:

First Name M. Last Name

Street

City State Zip

Phone

Account & Payment

Person responsible for account:

To Be Provided In Office
Signature

Preferred Method of Payment

- Cash or Check
- Credit Card (Card Number and Exp. Date to be provided in office)
- Alternative Billing Source (ask)

Signature: Date:

DENTAL INSURANCE COVERAGE

Employee

Name _____

Date of Birth _____

Relationship to Patient _____

Employer Name _____

Name of Insurance Company _____

How Many Years Employed _____

Address of Employer _____

Telephone # _____

Policy # _____

Social Security # _____

Union Local or Group _____