EverySmile Dental

10825 Boyette Road Riverview, FL 33569 | (813) 741-0483

PERSONAL INFORMATION

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. **Date:**_______/_______/__________

Last Name: ____________________________ **First Name:** ______________________________ **MI:** _________

Preferred Name (Nickname): __________________________________ **Date of Birth:**_____/______/________

SSN: ______ - _____ - ______ **Marital Status:** ( ) Married ( ) Single ( ) Other **Gender:** ( ) Male ( ) Female

Home Address: ____ **Apt #:**_______________

City: ______________________________________ **State:** _____________ **Zip Code:** __________________

Phone Number (Preferred): _(______)_________-____________ ( ) Cell ( ) Home ( ) Work ( ) Other

Phone Number (Alternate): _(______)_________-____________ ( ) Cell ( ) Home ( ) Work ( ) Other

Employer: _______________________________________ **Occupation:** ________________________________

May we call you at work? ( ) Yes ( ) No **Email Address:** ____

IN CASE OF EMERGENCY

Name: ____ **Phone:** _(______)_______-____________

Relationship: ____

HOW WERE YOU REFERRED TO OUR OFFICE?

( ) Internet (Google, Bing, Yahoo, etc.)
( ) Dental Insurance Company
( ) Friend
Name:____________________________________
( ) Facebook
( ) Saw Our Sign
( ) Other
Specify:____________________________________

Reason for Today's Visit: ( ) Routine Check-Up/Get Established as a New Patient.
( ) It's been a while, but I'm not having any problems.
( ) I have a problem I'd like addressed.
Explain: ____

DENTAL HISTORY

Name of Previous Dentist: ____ **Phone:** _(_____)______-__________

City/State: ___________________________________ **Date of Last Dental Appointment:** ___________________

Date of Last Professional Cleaning: __________________ **Date of Last Dental X-Rays:** ___________________

Do you have any crowns (caps)? ( ) Yes ( ) No

Does food catch between your teeth? ( ) Yes ( ) No

Are your teeth sensitive to the following?

Heat ( ) Yes ( ) No

Cold ( ) Yes ( ) No

Sweets ( ) Yes ( ) No

Biting/Chewing/Pressure ( ) Yes ( ) No

GUMS

Do you experience the following?

Bleeding gums when brushing ( ) Yes ( ) No

Swollen gums ( ) Yes ( ) No

Unpleasant taste/odor in mouth ( ) Yes ( ) No

Avoid part(s) of mouth while brushing ( ) Yes ( ) No

Bad breath ( ) Yes ( ) No

Have you ever been treated for
(or told you have) periodontal disease? ( ) Yes ( ) No **If treated, when?**_______________________

Do you floss regularly? ( ) Yes ( ) No **If yes, how often?** ______________________

TMJ/TMD

Do you experience the following?

Pain, popping or locking in jaw joint ( ) Yes ( ) No

Pain when opening wide or yawning ( ) Yes ( ) No

Clenching or grinding teeth ( ) Yes ( ) No

Frequent headaches, migraines ( ) Yes ( ) No

Frequent neck/shoulder aches ( ) Yes ( ) No

Shifting/loose teeth or changes in bite ( ) Yes ( ) No

COSMETIC

Do you like your smile? ( ) Yes ( ) No

Would you like your teeth whiter? ( ) Yes ( ) No

Have you had orthodontics (braces)? ( ) Yes ( ) No When was it completed?________________

Is there any old dental work you don't like? ( ) Yes ( ) No Specify:________________________________

Is there anything you would like to change? ( ) Yes ( ) No Specify: _______________________________

REPLACEMENT TEETH

Do you have any of the following?

Missing teeth	( ) Yes	( ) No
Bridges (fixed) to replace teeth	( ) Yes	( ) No
Partials (removable) to replace teeth	( ) Yes	( ) No
Dentures	( ) Yes	( ) No
Dental Implants to replace teeth	( ) Yes	( ) No
Dental Implants to support dentures	( ) Yes	( ) No

COMFORT

Have you ever had a bad experience in a dental office that caused you anxiety, or does a particular noise or action make you nervous? ( ) Yes ( ) No

Specify: ____

Have you had nitrous oxide (laughing gas)? ( ) Yes ( ) No

Have you had IV Sedation (conscious sleep)? ( ) Yes ( ) No

Have you had Oral Sedation (sedative)? ( ) Yes ( ) No

Are you interested in trying sedation? ( ) Yes ( ) No

PHYSICIAN'S INFORMATION

Office Name: ____ **Phone:** _(______)_______-__________

Physician's Name: ____________________________________ **Last Visit:** ______/_______/__________

GENERAL MEDICAL and HEALTH

Are you currently under a physician's care? ( ) Yes ( ) No

Specify: ____

Are you taking any medications? ( ) Yes ( ) No

Specify (include OTC drugs, vitamins, birth control, etc): ____

____

Do you have any health problems? ( ) Yes ( ) No

Specify:____

Have you ever had surgery? ( ) Yes ( ) No

Specify: ____

Are you allergic to any medications? ( ) Yes ( ) No

Medication: _________________________________ Reaction: ________________________________

Have you ever had a reaction to local anesthetic? ( ) Yes ( ) No

Specify: ____

Do you require premedication with antibiotics before appointments? ( ) Yes ( ) No

Specify: ____

GENERAL MEDICAL and HEALTH (cont'd)

To the best of your knowledge, do you have (or have you ever been afflicted) with any of the following?

Condition	Yes	No
Rheumatic Fever/ Heart Murmur	( ) Yes	( ) No
Mitral Valve Problems	( ) Yes	( ) No
Artificial joints or valves	( ) Yes	( ) No
Seizures/Epilepsy/Stroke	( ) Yes	( ) No
Heart Ailment	( ) Yes	( ) No
High Blood Pressure	( ) Yes	( ) No
High Cholesterol	( ) Yes	( ) No
Respiratory Disease	( ) Yes	( ) No
Asthma/Hay Fever	( ) Yes	( ) No
Diabetes	( ) Yes	( ) No
Thyroid Disease	( ) Yes	( ) No
Liver/Kidney Problems	( ) Yes	( ) No
Prolonged Bleeding	( ) Yes	( ) No
Healing Complications	( ) Yes	( ) No
Take Blood Thinners or Aspirin	( ) Yes	( ) No
Hepatitis/HIV	( ) Yes	( ) No
Gastrointestinal Problems	( ) Yes	( ) No
Drug/Alcohol Abuse	( ) Yes	( ) No
Do you smoke/ chew tobacco?	( ) Yes	( ) No
Are you taking any diet drugs?	( ) Yes	( ) No
Are you pregnant?	( ) Yes	( ) No

PATIENT TREATMENT CONSENT

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to present to me all of my options so that I may make an informed decision as to my course of treatment. Once treatment is agreed upon, I authorize the Dentist(s) to perform needed dental treatment and administer or prescribe any necessary medications.

I authorize my Dentist(s) to release treatment records, x-rays, or any other information deemed pertinent to my insurance carrier as necessary and/or requested to process my claims. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All payments are due at the time of service.

____   _____________________

Patient/Guardian Signature   **Date**

____

Dentist Signature