THE Smile Spa

Today's Date_____ Please give us some information……

ABOUT YOU:

Mr. Mrs. Ms. Miss. Dr._____
LAST FIRST MIDDLE

I prefer to be called: _____ Birthdate : _____

Home Address: _____
STREET CITY STATE ZIP CODE

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP CODE

E-Mail Address: _____

Telephone: (H)_____(W)_____(P)_____

Best Phone Number To Verify Dental Appointments During Business Hours: _____

Social Security Number: _____ Driver's License Number: _____

Employer: _____
NAME MAILING ADDRESS CITY STATE ZIP CODE

Whom May We Thank For Referring You: _____

Name and Address of Nearest Relative (Not Living With You):_____

_____ Phone:_____

ABOUT YOUR FAMILY

Other Family Members

_____	_____	_____	_____
NAME	BIRTHDATE	NAME	BIRTHDATE
_____	_____	_____	_____
NAME	BIRTHDATE	NAME	BIRTHDATE

ABOUT BILLING

Who is responsible for account balance? _____

Signs and Symptoms
Dental Examination Checklist

Name: _____ Age: _____ Date: _____

Please circle any of the following symptoms that you may be experiencing now or have experienced in the past.

Symptoms

1. Headaches
2. TMJ pain (Temporo-mandibular joint)
3. TMJ noise
4. Limited opening
5. Ear congestion
6. Vertigo (Dizziness)
7. Tinnitus (Ringing in the ears)
8. Dysphagia (Difficulty swallowing)
9. Loose teeth
10. Clenching/Bruxing/Grinding (Circle any that apply)
11. Facial pain (non-specific)
12. Tender, sensitive teeth
13. Difficulty chewing
14. Cervical (Neck) pain
15. Postural problems
16. Paresthesia of fingertips (Tingling)
17. Thermal sensitivity (Hot and/or cold)
18. Trigeminal nueralgia
19. Bell's Palsy
20. Nervousness/Insomnia
21. Sleep apnea

Dental History

Patient's Name _____ **Date** _____

Our dental office is very different than the average, ordinary dental office. We place a high emphasis on helping you determine your present and future dental needs and creating a **Personalized Dental Plan** that is specifically tailored to your specific desires and needs. What follows are some questions that will help us discover what those desires and needs are. These may be about issues you have never thought about, but thoughtful answers will help us to understand your personal situation so we can create an individual plan suited perfectly for you.

1. How long has it been since you have been to the dentist and what were you seen for? _____
   _____
2. What are your areas of concern right now or what is your major reason for seeing us? _____
   _____
3. Tell us your opinion about what you think the present state of the health of your mouth? _____
   _____
4. Tell us about your good dental experiences._____
5. What did you like about your last dentist?_____
6. Tell us about any bad experiences._____
7. What caused you to leave your last dentist?_____
8. What would you like to change about your smile?_____
9. What would it take for you to trust us to be your dentist?_____
10. Do you have any family members who already come to our office? **YES** **NO** Who?_____
11. What do you already know about our office and what are your expectations?_____
    _____
12. Has fear ever been an issue for you in a dental office? **YES** **NO**
13. Has time ever been a factor in getting your dental work done? **YES** **NO**
14. Has the cost of dental treatment been a concern for you? **YES** **NO**
    What can we do to help you with this?
15. We have the unique ability to look at your mouth from 3 different perspectives, what combination(s) of these would you like us to use for you?
    As a general dentist. **As a cosmetic dentist.** **As a functional (bite, TMJ) dentist.**
16. At what point do you want us to initiate treatment?
    When my tooth hurts/break. **When something worsens.** **When something isn't ideal.**
17. What quality of dentistry do you want us to recommend?
    "Just patch it" **Average** **Ideal/Best we can provide.**
18. Is there anything else you would like us to know?_____

Medical History

Patient's Name _____ Date _____

Medical Doctor's Name _____ Phone _____
Are you under a doctor's care now? **YES NO** Why? _____
Do we have your permission to contact her/him regarding your care? **YES NO**
Have you been hospitalized during the past two years? **YES NO** For what? _____
_____
Are you taking medications, pills or drugs? **YES NO** List drug(s) & reason for taking;
_____
_____
Do you require antibiotic pre-medication for your dental work? **YES NO**
What for? _____
Are you allergic to any medications or substance? **YES NO** List: _____
_____
Women: Are you pregnant? **YES NO** How far along? _____

Please <u>CIRCLE</u> if you have ever had any of the following:

Allergies	Diabetes	Hepatitis A	Rheumatism
Anemia	Dizziness	Hepatitis B	Scarlet Fever
Angina	Drug Addiction	Hepatitis C	Seizures
Artificial Heart Valve	Emphysema	Herpes	Shortness of Breath
Artificial Hip/Joints	Epilepsy	High Blood Pressure	Sickle Cell Anemia
Arthritis/Gout	Excessive Thirst	HIV+/AIDS	Sinus Trouble
Asthma	Fainting	Hypoglycemia	Stroke
Blood Disease	Fever Blisters	Kidney Disease	Swelling of Limbs
Blood Transfusion	Frequent Cough	Liver Disease	Tattoos/Body Piercing
Bruise Easily	Glaucoma	Low Blood Pressure	Thyroid Disease
Cancer	Hay Fever	Lung Disease	TMD/TMJ
Chemotherapy/Radiation	Heart Murmur	Nervousness	Tuberculosis
Chest Pain	Heart Pacemaker	Pain in Jaw Joints	Ulcers
Cold Sores	Heart Surgery	Parathyroid Disease	Venereal Disease
Congenital Heart Lesion	Heart Trouble	Psychiatric Care	X-ray or Cobalt Tmt.
Cortisone Medicine	Hemophilia	Rheumatic Fever	Yellow Jaundice

Have you ever had any other serious illness not circle above? **YES NO**
Please describe in detail; _____
Are you being/have you ever been treated for cancer of any kind? **YES NO**
Please explain; _____
Do you wish to talk to the doctor privately about any problems/concerns? **YES NO**

_____ _____
Patient Signature (Parent or Guardian) Date

Reviewed by: _____ _____ _____
(Title) Date BP

SMILE ANALYSIS

Name: _____ Date: _____

When you see your smile in the mirror, do you like the way your teeth look? __YES __ NO

Is there something about your smile you would like to change? __YES __ NO

Do you have:

- discolored teeth? __YES __ NO
- chipped or worn edges? __YES __ NO
- spaces or gaps between your teeth? __YES __ NO
- crooked teeth? __YES __ NO
- to much gum showing? __YES __ NO
- dark/ silver fillings? __YES __ NO
- caps or crowns you are unhappy with? __YES __ NO
- any other concerns/ complaints? __YES __ NO

Would you like to whiten your teeth? __YES __ NO

Have you ever seen teeth TOO white? __ YES __ NO

Do you have habits that might discolor your teeth? __YES __ NO

Describe: _____

Do you clench or grind your teeth? __YES __ NO

Do you ever get an unpleasant taste in your mouth or coating on your tongue? __YES __ NO

Do you rely on gums, mints or gel strips during the day? __YES __NO

Do you notice an unpleasant odor on your dental floss? __YES __NO