Patient Form

Smile Source

GENERAL INFORMATION

First Name | Last Name | MI | Preferred

Street Address

City | State | Zip

Home Phone | Cell Phone | E-mail

Preferred Contact Method

☐ Cell Phone ☐ E-Mail ☐ Text ☐ Home Phone

Date of Birth | Social Security Number | Gender

◯ Male ◯ Female

Occupation/Employer

Marital Status

◯ Married ◯ Single ◯ Divorced ◯ Widowed

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Dental Insurance

Dental Insurance Member Name

Dental Insurance Member ID#

Dental Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Relationship to Primary Member

◯ Spouse ◯ Child

◯ Other

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/ Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

◯ Spouse ◯ Child

◯ Other

DENTAL INFORMATION

Have you ever had orthodontic (braces) treatment?

◯ Yes ◯ No ◯ DK

Are your teeth sensitive to cold, hot, sweets or pressure?

◯ Yes ◯ No ◯ DK

Do your gums bleed when you brush or floss?

◯ Yes ◯ No ◯ DK

Is your mouth dry?

◯ Yes ◯ No ◯ DK

Is your home water supply fluoridated?

◯ Yes ◯ No ◯ DK

Do you have earaches or neck pains?

◯ Yes ◯ No ◯ DK

Have you had any periodontal (gum) treatments?

◯ Yes ◯ No ◯ DK

Do you drink bottled or filtered water?

◯ Yes ◯ No ◯ DK

Have you ever had orthodontic (braces) treatment?

◯ Yes ◯ No ◯ DK

Does food or floss catch between your teeth?

◯ Yes ◯ No ◯ DK

Do you have any clicking, popping or discomfort in the jaw?

◯ Yes ◯ No ◯ DK

Have you ever had a serious injury to your head or mouth?

◯ Yes ◯ No ◯ DK

Do you brux or grind your teeth?

◯ Yes ◯ No ◯ DK

Date of your last dental exam:

Date of last dental x-rays:

Do you have sores or ulcers in your mouth?

◯ Yes ◯ No ◯ DK

Do you participate in active recreational activities?

◯ Yes ◯ No ◯ DK

Do you wear dentures or partials?

◯ Yes ◯ No ◯ DK

Are you currently experiencing dental pain or discomfort?

◯ Yes ◯ No ◯ DK

How do you feel about your smile?

What was done at that time?

What is the reason for your dental visit today?

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Select all that apply.

AIDS/HIV

☐ Yes
☐ No
☐ Family

Allergies

☐ Yes
☐ No
☐ Family

Arthritis

☐ Yes
☐ No
☐ Family

Asthma

☐ Yes
☐ No
☐ Family

Blood/Lymph Disorder

☐ Yes
☐ No
☐ Family

Cancer

☐ Yes
☐ No
☐ Family

Ears, Nose, Throat Conditions

☐ Yes
☐ No
☐ Family

Diabetes

☐ Yes
☐ No
☐ Family

Gastrointestinal Conditions

- ☐ Yes
- ☐ No
- ☐ Family

Heart Disease

- ☐ Yes
- ☐ No
- ☐ Family

High Blood Pressure

- ☐ Yes
- ☐ No
- ☐ Family

High Cholesterol

- ☐ Yes
- ☐ No
- ☐ Family

Kidney Disease

- ☐ Yes
- ☐ No
- ☐ Family

Lupus

- ☐ Yes
- ☐ No
- ☐ Family

Neurological Conditions

- ☐ Yes
- ☐ No
- ☐ Family

Psychiatric Disorder

- ☐ Yes
- ☐ No
- ☐ Family

Seizures

- ☐ Yes
- ☐ No
- ☐ Family

Skin Conditions

- ☐ Yes
- ☐ No
- ☐ Family

Stroke

- ☐ Yes
- ☐ No
- ☐ Family

Thyroid Dysfunction

- ☐ Yes
- ☐ No
- ☐ Family

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Are you pregnant or nursing?

Height

Weight

Do you smoke?

Have you ever smoked?