Just Smile Dental
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JUST SMILE DENTAL

PLEASE COMPLETELY FILL OUT THIS FORM

Name:

Address:

City: State: Zip:

Date of Birth: Soc.Sec.#:

Email: Phone #:

How did you hear about us?

Do you plan on using dental Insurance? ☐ Y ☐ N
If so, who is your provider? Your member ID #:

Reason for today's visit? ☐Check-up ☐Cleaning ☐Toothache
☐Other:

DENTAL HISTORY

Are there other dental conditions which we should be aware of?

When did you last visit a dentist?

What treatment was performed?

Was the treatment completed? ☐ Y ☐ N Did you have a cleaning? ☐ Y ☐ N
When were dental x-rays last taken?

Are you missing any teeth? ☐ Y ☐ N Did you have your wisdom teeth removed? ☐ Y ☐ N
Have you had gum (periodontal) treatment? ☐ Y ☐ N
Have you ever had prolonged bleeding after an extraction? ☐ Y ☐ N
Have you had any problems with past dental treatment? ☐ Y ☐ N
Do you grind your teeth, clinch your jaws or have any symptoms near your ears, such as clicking, popping, pain or locking open? ☐ Y ☐ N
Have you ever been diagnosed or treated for TMD (temporomandibular Joint Dysfunction) sometimes called TMJ? ☐ Y ☐ N

Do your gums bleed easily? ☐ Y ☐ N
Are your teeth sensitive to hot or cold? ☐ Y ☐ N
Would you like your teeth whiter? ☐ Y ☐ N
Do you have a family history of bad teeth? ☐ Y ☐ N

Do you have issues with bad breath? ☐ Y ☐ N
Are you happy with your smile? ☐ Y ☐ N

If so who? (ie. Parents, siblings, etc.) And what were the conditions? (Dentures, tooth decay, etc.)

Is there anything you would like to improve about your smile? ☐ Y ☐ N

MEDICAL HISTORY

Are you under a doctor's care at this time? ☐ Y ☐ N
Dr. Name:

Do you have **ANY** allergies? For example, **metal**, penicillin, **latex**, etc.: ☐ Y ☐ N
If yes, please list:

Are you taking any medications at this time, including birth control? ☐ Y ☐ N
If yes, please list: _____

(Women) are you pregnant? ☐ Y ☐ N If yes, how many months? _____ Are you nursing? ☐ Y ☐ N
Are there any other health problems of which we should be advised? Please Specify: _____

_____

_____

Do you have, or have you had, any of the following:

HEART CONDITIONS
☐Artificial Heart Valve ☐Angina
☐Heart Attack/Surgery ☐Heart Murmur/Problems
☐High Blood Pressure ☐Low Blood Pressure
☐Pacemaker
Current Blood Pressure: _____
Current Weight: _____

IMMUNOLOGICAL
☐HIV/AIDS ☐Venereal Disease

BONE AND JOINT CONDITIONS
☐Arthritis ☐Bisphosphonate Therapy
☐Joint Replacement ☐Osteoporosis

RESPIRATORY
☐Asthma ☐Emphysema
☐Lung Disease ☐Sinus Trouble
☐Tuberculosis

KIDNEY CONDITIONS
☐Kidney Disease

NEUROLOGICAL CONDITIONS
☐Epilepsy ☐Stroke

MENTAL HEALTH
☐Psychiatric Care ☐Anxiety
☐Depression ☐Bipolar
☐Other: _____

LIVER CONDITIONS
☐Liver Problems ☐Hepatitis
☐Jaundice

OTHER CONDITIONS
☐Anemia ☐Bleeding Problems
☐Cancer ☐Chemo/RAD Therapy
☐Cosmetic Surgery ☐Diabetes
☐Dizzy Spells ☐Drug Addiction
☐Fainting ☐Glaucoma
☐Rheumatic Fever ☐Sleep Apnea
☐Tobacco

Emergency Contact:
Spouse's Name: Other: _____
Phone Number: _____
Do you have any family members who may be in need of dental care? _____

_____

Employment:
Occupation: Employer: _____

_____ _____
Patient Signature Date

_____ _____
Signature of legal guardian Date