WELCOME

CENTURY SMILE DENTAL

General, Cosmetic, and Implant Dentistry

PATIENT INFORMATION

Date:________________________________

Name:_______________________________

Street Address:_______________________

City:___________ State:___ Zip:________

Telephone: Home (____) _______________

Telephone: Cell (____) _______________

Telephone: Work (____) _______________

E-mail:_______________________________

Sex: __F __M Date of Birth:__________

Social Security No.:___________________

Occupation:________ Employer:_________

Employer's Address:___________________

Emergency Contact:____________________

Emergency Contact Tel: (___) ___________

How were you referred to us?
Friend or Family (please specify):_________
Internet (please specify):________________
News/Mag (please specify): ______________
Other (please specify):__________________

DENTAL INSURANCE

Insurance Co.:________________________

Subscriber's Name:____________________

Subscriber's Relationship to Patient:______

Group No.:___________________________

Any Additional Insurance?:___Yes ___ No

Subscriber's Name:____________________

Date of Birth:______ SS#____________

Group No.:___________________________

ASSIGNMENT & RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with __________________ and assign directly to Century Smile Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Print Name-Patient, Parent/Guardian, or Representative

____
Signature-Patient, Parent/Guardian, or Representative

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DENTAL HISTORY

Reason for today's visit:____________________
Date of last dental visit:____________________
Date of last dental x-rays:____________________

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or check biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss?____________________
How often do you brush?____________________

DENTAL HISTORY CONTINUED

Do you like the appearance of your teeth, your smile?	☐ Yes	☐ No
Are your teeth all straight?	☐ Yes	☐ No
Do you have spaces between your teeth that you do not like?	☐ Yes	☐ No
Do you like the color of your teeth?	☐ Yes	☐ No
Do you like the shape of your teeth?	☐ Yes	☐ No
Are your teeth chipped, protruding, and/or hidden?	☐ Yes	☐ No
Do you like the way your teeth come together?	☐ Yes	☐ No
Are there old fillings/dental work that you do not like the look of?	☐ Yes	☐ No

What would you like to change about the appearance of your teeth? ____________________
____

How would you like your teeth to look? __________
____

Medications (please list any medications you are currently taking):____________________
Allergies (please list anything, including medications, that you are or may be allergic to):
____

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HEALTH HISTORY

Physician's Name:__________________________

Date of last visit:____________________________

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)

☐ Yes ☐ No

Condition		
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

HEALTH HISTORY CONTINUED

Condition		
Heart murmur	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Hepatitis Type _________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw pain	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No
Nervous problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric care	☐ Yes	☐ No
Radiation treatment	☐ Yes	☐ No

Condition		
Back problems	☐ Yes	☐ No
Bleeding abnormally with extractions or surgery	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No
Congenital heart lesions	☐ Yes	☐ No
Cortisone treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Condition		
Respiratory disease	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Scarlet fever	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Skin rash	☐ Yes	☐ No
Special diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen feet or ankles	☐ Yes	☐ No
Swollen neck glands	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No
Weight loss, unexplained	☐ Yes	☐ No