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PATIENT INFORMATION

Name____ Date of Birth__________________________
Home Phone _______________________Cell Phone ___________________Work Phone_______________
What is the best time to reach you?__________________________
Address_____________________________________City_____________State_____Zip_______________
Social Security#_________________________ Email____
Marital Status__________________________

Patient's Employer____________________________
Business Address______________________________City_____________State_____Zip________________
Spouse or Parent's Name______________________________Employer_______________________________
Work Phone__________________________________
Person to contact in case of emergency______________________________________
Phone(1)__________________________________Phone(2)________________________

RESPONSIBLE PARTY

Name of Person Responsible for Account______________________________
Relationship to Patient____
Address____ Home Phone________________
Social Security#____Birthdate____________________________
Employer____Work Phone_________________________
Occupation____
Is this person currently a patient in our office?___________

DENTAL INSURANCE INFORMATION

Name of Insured_____________________________________
Relationship to Patient_________________________________
Birthdate of Insured__________________________________ Social Security#___________________________
Name of Employer____Work Phone__________________________
Address of Employer_________________________________City_______________State____ Zip____________
Insurance Company__________________________________Group #_____________Phone________________
Ins. Co. Address______________________________________City_______________State____Zip____________

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____ Date_______________________

MEDICAL HISTORY FORM

Patient's name______________________________ Date______________________________________

Name of Physician_______________________________Address_________________________________

Have you been under a physician's care during the past 2 years?_____If yes, for__________________________

Have you ever had major surgery?____ If yes, date and procedure_______________________________

Do you smoke or use tobacco in any form?____If so, what type and how much?________________________

Are you now taking or have you taken any prescription drugs during the past year?_______________________

If yes, please list:____

____

Women:

Are you pregnant?____________ Nursing?_______________ On birth control pills?____________________

Have you had an allergic reaction or a bad reaction to any of the following?

☐ Penicillin ☐ Local Anesthetic ☐ Codeine ☐ Sulfa drugs ☐ Iodine

☐ Aspirin ☐ Latex ☐ Barbiturates ☐ Other_____________________

Please check if you have or have had any of the following conditions:

☐ Heart murmur
☐ High blood pressure
☐ Chest pain(angina)
☐ Congestive heart failure
☐ Mitral Valve Prolapse
☐ Arrythmia
☐ Artificial heart valves
☐ Pacemaker
☐ Heart surgery
☐ Rheumatic Fever
☐ Stroke
☐ Hip/Knee replacement
☐ Diabetes
☐ Glaucoma
☐ Thyroid disease
☐ Cancer: type____________
☐ Radiation treatment
☐ Chemotherapy
☐ Cortizone treatment
☐ Kidney Disease
☐ Liver Disease
☐ Hepatitis A, B or C
☐ Asthma
☐ Allergies/Hives
☐ Sinus trouble
☐ Emphysema
☐ Tuberculosis(TB)
☐ Anemia
☐ Sickle cell anemia
☐ Prolonged bleeding
☐ Bruise easily
☐ Hemophilia
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Osteoporosis
☐ Lupus
☐ Autoimmune disease______________
☐ HIV/AIDS
☐ Seizures
☐ Fainting/Dizziness
☐ Drug Dependence
☐ Psychiatric treatment
☐ Other____________________________

I understand that the information contained in my records is confidential. However, I give my consent for Dr. Semo to release to my physician any information which may be helpful in her understanding of my present health condition.

Patient Signature____ Date______________________________

DENTAL HISTORY FORM

When was your last dental visit?__________________How often did you see the dentist?_______________
Do you have any urgent dental needs?____
Do any of the following trigger dental discomfort? Hot_______ Cold______ Sweets_____ Chewing______
How often do you brush your teeth? _____________ How often do you floss?_________________________
Do you use mouthwash?___________
Do you suffer from halitosis (bad breath)? __________________ If yes, do you know the cause?__________
Have you had periodontal gum treatment?__________________ If yes, when?__________________________
Do you clench or grind your teeth?________________________Do your jaws ache?_____________________
Have you had orthodontic (braces) treatment?_______________ If yes, when?_________________________
Do you usually have many cavities?______________________Do you lose or break fillings?_____________
Do you have any loose teeth?__________________________Cracked or broken teeth?__________________
Are you missing any teeth?____________________________ Have they been replaced?_________________
Do you have any of the following? Implant(s)_____________Fixed bridge_____________
Removable partial_______________ Full denture________________
Have you ever had an unpleaseant dental experience?_______ Please explain___________________________
____
Why did you leave your last dentist?____

Please answer the following:
My teeth feel:
☐ Very comfortable ☐ Moderately comfortable ☐ Uncomfortable

☐ I am satisfied with the appearance of my mouth
☐ I am dissatisfied with the appearance of my mouth

I think my present state of dental health is:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

I would like a mouth with:
☐ Excellent health ☐ Good health ☐ Fair health ☐ Poor health

I have:
☐ Put dentistry for myself and my family high on my priority list
☐ Put dentistry for myself and my family low on my priority list

I have always:
☐ Done the best to follow through with what is recommended for my dental health
☐ Have not followed through with what was recommended
☐ Not given much thought to my dental care

I have:
☐ Set goals for my oral health with a previous dentist
☐ Wanted to set goals for my oral health
☐ No interest in setting goals for my oral health.

SMILE EVALUATION FORM

Name:____ Date______________________________

Do you like the appearance of your smile?_____________
If no, what bothers you the most?____

Do you consider your teeth to be straight or properly aligned?_____________________________________

Do you have spaces between your teeth that you don't like?_______________________________________

Do you like the color of your teeth?____

Do you like the shape of your teeth?____

Do you like the way your upper teeth meet your lower teeth?_______________________________________

Do you consider your existing fillings or dental work to be unattractive?_________
If yes, please describe____

Do you find that your gums are unattractive?____

If yes, do they bleed easily, or are they receded?____

What would you like to change the most in the appearance of your teeth and in your dental health?

____
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____
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