

Smile Creations Dental

Family and Cosmetic Care

Drs. Patel & Patel

623.434.9868

www.PatelDental.com

Patient Information

Patient Name _____ Date _____
Last First MI (Preferred Name)

Gender: Male / Female Family Status: Married Single Divorced Other _____

Social Security #: _____ Birth Date _____

Phone (Home): _____ (Work) _____ Ext _____ (Cell): _____

Address: _____
Street Apartment #
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Another Patient, Friend Another Patient, Relative
 Mailer Yellow Pages Newspaper Internet Work Other _____

Name of person or office referring you to our practice: _____

Health Information

Do you have, or have had any of the following? Please check those that apply Yes:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Scarlet Fever* | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Surgery* | <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Irregular Heart Beat* | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> AIDS | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Allergies (Pollen/Dust) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Shunts | <input type="checkbox"/> Hives or Rash |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Cold Sores | Due Date _____ |

Current medications being taken (Please List) _____

Allergies to medications (Please List) _____

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No Name of Physician and Phone #: _____

If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Patient Name _____ Last First MI (Preferred Name)	Date: _____
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Date of Last Dental Visit: _____ Last Dentist's Name _____

Reason for this visit: _____

Are your teeth sensitive to:

- | | | |
|------------------|------------------------------|-----------------------------|
| Heat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sweets? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Biting Pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Problems of the Jaw:

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| Clicking of the Jaw? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain (joints, ear, side of face) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty opening or closing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty chewing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- | | | |
|---|------------------------------|-----------------------------|
| Does food catch between your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do your gums bleed when brushing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you noticed any gum swelling around any teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have an unpleasant taste or odor in your mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you dissatisfied with your teeth or their appearance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you happy with your SMILE ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever considered Whitening your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you smoke? If yes, how many per day? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Is there anything else you feel is important for us to know in regards to your dental health? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Doctor's Initials _____

