



ROSEVILLE SMILES

Family and Cosmetic Dentistry

PATIENT INFORMATION

| | | |
|-------------------------------|-----------------------|----------------------------------|
| First Name: _____ | Last Name: _____ | Gender: _____ |
| Date of Birth: _____ | Mobile Phone #: _____ | Email: _____ |
| Address: _____ | | |
| Emergency Contact Name: _____ | | Emergency Contact Phone #: _____ |

RESPONSIBLE PARTY

| | | |
|----------------------|-------------------------------|--------------------------|
| Relationship: _____ | First Name: _____ | Last Name: _____ |
| Date of Birth: _____ | Social Security Number: _____ | Phone Number: _____ |
| Email: _____ | | |
| Employer Name: _____ | | Work Phone Number: _____ |
| Address: _____ | | |

PREFERRED PHARMACY

| | |
|----------------------|-----------------------|
| Pharmacy Name: _____ | Pharmacy Phone: _____ |
| Address: _____ | |

POLICY HOLDER

| | | |
|----------------------------|--------------------------------|----------------------|
| Insured First Name: _____ | Insured Last Name: _____ | Gender: _____ |
| Relation to Patient: _____ | Insured Social Security: _____ | Date of Birth: _____ |

PRIMARY INSURANCE

| | | |
|-----------------------|-------------------------|-------------------|
| Insurance Name: _____ | Ins Phone Number: _____ | |
| Policy ID: _____ | Group #: _____ | Group Name: _____ |
| Address: _____ | | |

I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.

I agree to receive SMS updates at the phone number provided above and understand that message frequency may vary. Msg & data rates may apply. Reply STOP to opt out.

If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

| | |
|--|--------------------|
| Physician's Name _____ | Phone Number _____ |
| Can we contact your physician if we have a question about your health as it relates to your treatment? <input type="checkbox"/> <input type="checkbox"/> | |
| Are you in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No Height _____ Weight _____ | |
| Are you currently taking or planning to take antibiotics before dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you been hospitalized in the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you under care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Have you ever had general anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or your family had reactions to general anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

ALLERGIES/REACTIONS

| | | | |
|--|--|--|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> <input type="checkbox"/> Amoxicillin |
| <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> <input type="checkbox"/> Latex | <input type="checkbox"/> <input type="checkbox"/> Do you have any known allergies |

Please list any allergies not listed above

MEDICAL CONDITIONS**Do you have, or have you had, any of the following diseases, medical conditions, or procedures?**

| | | | |
|---|--|---|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> <input type="checkbox"/> Dementia | <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> Prosthetic implant |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> High cholesterol | <input type="checkbox"/> <input type="checkbox"/> History of Radiation |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Do you smoke or vape | <input type="checkbox"/> <input type="checkbox"/> History of alcohol / drug abuse | <input type="checkbox"/> <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease | Number of smoke/day | <input type="checkbox"/> <input type="checkbox"/> History of marijuana / drug use | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco | <input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> <input type="checkbox"/> Sleep apnea / CPAP |
| <input type="checkbox"/> <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Joint replacement | <input type="checkbox"/> <input type="checkbox"/> Special diet |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Fainting spells | <input type="checkbox"/> <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> <input type="checkbox"/> Stomach ulcers / acid reflux |
| <input type="checkbox"/> <input type="checkbox"/> Bruise easily | <input type="checkbox"/> <input type="checkbox"/> Hay fever / Sinus problems | <input type="checkbox"/> <input type="checkbox"/> Liver disease | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart attack(s) | <input type="checkbox"/> <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> <input type="checkbox"/> Heart murmur | <input type="checkbox"/> <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs |
| <input type="checkbox"/> <input type="checkbox"/> Chronic cough | <input type="checkbox"/> <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> <input type="checkbox"/> Mental health problems | <input type="checkbox"/> <input type="checkbox"/> Tumor or growth |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweat | <input type="checkbox"/> <input type="checkbox"/> Heart surgery | <input type="checkbox"/> <input type="checkbox"/> Osteopenia | <input type="checkbox"/> <input type="checkbox"/> Headache |
| <input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> <input type="checkbox"/> Heart valve issues | <input type="checkbox"/> <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> <input type="checkbox"/> Delay in healing | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Problems with immune system | <input type="checkbox"/> <input type="checkbox"/> Have you had infective endocarditis ? |

Any other medical conditions not listed above

X

X

Signature of patient

Date

Signature of dentist

Date

MEDICATIONS

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

| Medication Name | Dosage | Frequency | Medication Name | Dosage | Frequency |
|-----------------|--------|-----------|-----------------|--------|-----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

DENTAL HISTORY

Rate your mouth condition: _____ How frequently you see dentist?: _____ month(s)

Who may we thank for referring you?: _____ Most recent X-Rays: _____

Previous Dentist: _____ How long have you been patient?: _____

Date of last regular dental cleaning: _____ Most recent dental exam: _____

Describe your immediate concern:

PERSONAL HISTORY

How fearful are you of dental treatment (10 being the most)?: _____

Have you had an unfavorable dental experience? Yes No

GUM AND TEETH

Do you have missing teeth? If so, are you interested in Dental Implant? Yes No

Do your teeth feel like they fit together properly when you bite down? Yes No

Have you ever had deep cleaning of your teeth? Yes No Do you clench or grind your teeth? Yes No

History of getting therapeutic botox for sore jaw muscle or headache? Yes No

Do you feel like teeth have worn down overtime? If yes, remember to ask us about smile makeover. Yes No

GETTING TO KNOW YOU

What do you expect from your visit with us today?

If you could "enhance" anything about your smile what would it be?

Has "fear" or "cost" ever prevented you from getting the dental treatment you need or want? Yes No

What "quality" of dentistry do you want us to focus on at this time? _____

Should you be in need of treatment at what point do you plan to "get started"?

Please feel free to let us know more about how we can help make this your best dental experience.

DOCTOR'S NOTES