# BLESSED SMILES DENTISTRY

# PATIENT INFORMATION FORM

**Today's Date**______________________

Patient Name: First____________________ MI___ Last____________________ Preferred Name: _____________

Gender: ☐ M ☐ F SSN: ____________________ Birth Date (mm/dd/yyyy): ________________________

Address: Street__________________________________________ City______________ State____ Zip_________

Phone: Home________________ Work________________ Mobile_________________ Text Msg OK? ☐ Y ☐ N

E-mail: _______________________________________________________________________________________

Referred to us by: __________________________________________________

## Current Medication

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

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

## Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex

☐ Barbiturates (Sleeping pills) ☐ Aspirin ☐ Iodine

☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

| Name | Reaction |
|---|---|
| | |
| | |

## Dental History

When was your last dental exam?

Date ________________________

When was your last dental x-ray taken?

Date ________________________

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

# times/ day ___________ # times/ day ___________

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials

☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold

☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat

☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets

☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure

☐ Dentures ☐ Mouth Pain ☐ Swollen Gums

☐ Mouth Sores ☐ Difficulty Opening and Closing

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**Lifestyle Factors**

Have you ever smoked?

☐ Yes ☐ No # of Years ______ # of Packs/ day ______

Do you smoke now?

☐ Yes ☐ No # of Years ______ # of Packs/ day ______

Do you use recreational drugs?

☐ Yes ☐ No Types? ____________ # times/ week _____

How much alcohol do you drink per week?

# drinks/ week ______________________

How much caffeine do you drink per day?

# drinks/ day ______________________

**Women Only**

| Are you pregnant? | Are you breastfeeding? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

**Past Medical History**

Have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| ☐ Alcoholism | ☐ Bleeding Disorder | ☐ Eating Disorder | ☐ High Cholesterol | ☐ Migraines | ☐ Stomach Ulcer |
| ☐ Allergies | ☐ Blood Disease | ☐ Epilepsy | ☐ Joint Disorder | ☐ Osteoporosis | ☐ Substance Abuse |
| ☐ Anemia | ☐ Blood Transfusion | ☐ Hay Fever | ☐ Kidney Disorder | ☐ Pacemaker | ☐ Thyroid Disorder |
| ☐ Anxiety Disorder | ☐ Bowel Disorder | ☐ Heart Disease | ☐ Liver Disorder | ☐ Rheumatic Fever | ☐ Tuberculosis |
| ☐ Arthritis | ☐ Cancer | ☐ Heart Problems | ☐ Lung Disorder | ☐ Sinus Problems | ☐ Venereal Disease |
| ☐ Asthma | ☐ Diabetes | ☐ Hepatitis- A, B or C | ☐ Lupus | ☐ Skin Disorder | ☐ Major Surgery |
| ☐ AIDS / HIV | ☐ Depression | ☐ High Blood Pressure | ☐ Measles | ☐ Stroke | ☐ Joint Replacement |

**RELEASE:**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

**I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.**

I attest to the accuracy of the information on this page.

**Patient's / Guardian's Signature** **Date**