thesmilestudio®

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name _____

Preferred Name _____

☐ Male ☐ Female

Single Married Divorced Widowed Separated

Birth Date _____ Age _____

SS# _____

Address _____

City _____ State _____ Zip _____

Email _____

Home # _____ Work # _____

Mobile # _____ Fax # _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Last dental visit date _____

Employer _____

Employer Ph. # _____

Employer Address _____

How long employed there? _____

SPOUSE INFO

Name _____

Birth Date _____ Home # _____

Mobile # _____ Work # _____

Email _____

2 INSURANCE

Provider Name _____

Provider Address _____

City _____ State _____ Zip _____

Phone # _____

Group # _____

ID # _____

Insured's Birth Date _____

Insured's Employer _____

Insured's Phone # _____

Insured's SS # _____

*ID # is sometimes different than SS#

IF YOU HAVE A SECONDARY INSURANCE,
PLEASE LET A TEAM MEMBER KNOW.

3 ACCOUNT INFO

PERSON REPSPONSIBLE FOR ACCOUNT

Name _____ Relation _____

Home # _____ Work # _____

Mobile # _____ Birth Date _____

Email _____

Billing Address _____

City _____ State _____ Zip _____

Thank you for filling this form out completely.
It will allow us to serve you more effectively.
If you have questions at any time, please ask us.
We are happy to help.

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4 REMINDER INFO

To help you remember your appointments, we use an electronic appointment reminder and messaging system. Please check all that you prefer as our best way to contact you.

- ☐ Email only
- ☐ Text message only
- ☐ Text message and Email
- ☐ Personal phone call
- ☐ Don't need a reminder

Home#_____ Work#_____

Mobile#_____

5 CONTACT INFO

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

Name_____

Relation_____

Home #_____ Work #_____

Mobile #_____

Have you ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when?

Are you taking any medications for Osteoporosis

☐ Yes ☐ No

If so, what? _____

_____

6 MEDICAL HISTORY

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone #_____ Last visit date _____

Are you currently under the care of a physician?

☐ Yes ☐ No

If yes, explain _____

_____

Your current condition ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Dental Anesthetics	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No
Jewelry/Metals	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Tetracycline	☐ Yes	☐ No
Other	☐ Yes	☐ No

List any other drugs/materials that you are allergic to:

_____

_____

_____

Please continue section 6 on the next page...

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HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Abnormal bleeding	☐ Yes	☐ No
Alcohol/Drug abuse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial bones, joints, or valves	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Congenital heart defect	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Difficulty breathing	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting spells	☐ Yes	☐ No
Frequent headaches	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hay fever	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Herpes/Fever blisters	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
HIV+/AIDS	☐ Yes	☐ No
Hospitalized for any reason	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Mitral valve prelapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric problems	☐ Yes	☐ No
Radiation treatment	☐ Yes	☐ No
Rheumatic/Scarlet fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Shingles	☐ Yes	☐ No
Sickle Cell disease	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No

Please list any medical condition(s) you have ever had:

_____

_____

Do you have trouble sleeping?

☐ Yes ☐ No

Do you feel tired or fatigued after sleep?

☐ Yes ☐ No

Do you feel like you get enough sleep at night?

☐ Yes ☐ No

Do you have a CPAP?

☐ Yes ☐ No

If so, do you wear it?

☐ Yes ☐ No

FOR WOMEN ONLY

Are you taking birth control pills?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No

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7 DENTAL HISTORY

Why have you come to the dentist today?

Has your doctor told you that you require antibiotics before dental treatment?
☐ Yes ☐ No

Are you currently in pain?
☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work?
☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
☐ Yes ☐ No

Your current dental health is
Good Fair Poor

Do you like your smile?
☐ Yes ☐ No

Do your gums ever bleed?
☐ Yes ☐ No

How many times a week do you floss?

How many times a day do you brush?

Type of toothbrush bristles?
Hard Medium Soft

8 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees, and court costs.

Signature _____ Date _____

Print name _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT
UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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WELCOME. WE'RE GLAD YOU'RE HERE!

To better serve you, please take just a couple of minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- ○ Sensitivity (hot, cold, or sweet)

If so, which teeth?

- ○ Headaches, earaches, neck pain
- ○ Teeth or fillings breaking
- ○ Grinding or clenching teeth
- ○ Bleeding, swollen or irritated gums
- ○ Loose, tipped, or shifting teeth
- ○ Bad breath

Do you Smoke or use chewing tabacco?

☐ Yes ☐ No

if yes, how much? And, for how long?

Do you have, or have you had, any of the following?

- ○ Dentures
- ○ Partial dentures
- ○ Periodontal (gum) treatments

Who was your previous dentist?

Name: _____

City _____ **State** _____

Phone: ( ) _____

What are the most important things to you about your smile and dental health?

If you could whiten your teeth, at a cost that anyone could afford, would you like to?

☐ Yes ☐ No

If you could change your smile, would you:
(please check all that apply)

- ○ Make your teeth whiter
- ○ Make your teeth straighter
- ○ Close spaces between teeth
- ○ Replace black metal fillings with tooth-colored restorations
- ○ Repair chipped teeth
- ○ Replace missing teeth
- ○ Replace old crowns that don't match
- ○ Have a smile makeover

On a 1 to 5 scale, 5 being the highest rating:
(please circle the number that best applies)

How important is your dental health to you:

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health to be?

1 2 3 4 5

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?

Patient Name _____

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Consent to Proceed

I authorize Dr. Chad Ellis and such assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an unpleasant reaction or side effects, which may include, but are not limited to bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after complication of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including but not limited to crowns, small instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for the benefit of my minor child or ward. I acknowledge the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____