Welcome

The benefits of a happy, healthy smile are immeasurable!

Our goal is to meet you where you are, and then 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.

About You

Name_____
Preferred Name _____ Male Female

Single Married Divorced Widowed Separated

Birth Date _____ Age _____SS#_____

Address_____

City _____State _____ Zip_____

Email Address_____

Cell # _____Work#_____

Home # _____ Fax #_____

Employer _____ Employer #_____

How long have you been employed there? _____

We want to get to know you! Tell us a little bit about yourself:

family, job, favorite foods, favorite movies, favorite music, favorite things to do_____

_____

How did you hear about us? _____

_____

Dental History

Why have you come to see us today? _____

_____

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

- ☐ Tooth Sensitivity (hot, cold, or sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Jaw joint pain
- ☐ Headaches, ear aches, neck pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifting teeth
- ☐ Bad breath or bad taste in mouth
- ☐ Cold sores
- ☐ Oral cankers
- ☐ Snoring (you or someone you know)
- ☐ Anxiety or fear of dental procedures or shots?

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Periodontal (gum) disease
- ☐ Scaling and root planing
- ☐ Braces/ Orthodontics

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Please share your dental hygiene habits:

How many times a week do you floss? _____
How many times a day do you brush? _____
What kind of toothbrush bristles do you use?
Hard Medium Soft
Do you smoke or use tobacco? Yes No
If Yes, how much? How long?

Who was your previous dentist?

Name _____
City _____ State _____
Phone _____

Why did you leave your previous dentist?

_____
_____

Have you ever had serious/ difficult problems associated with previous dental work? Yes No
Please Explain. _____
_____

If you could change your smile, would you:

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Close the spaces between teeth
- ☐ Replace black metal fillings w/ tooth colored
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that do not match
- ☐ Have a smile make over

Do you like your smile? Yes No

On a scale of 1 to 10, with 10 being the highest rating:
(please circle the number that best applies to you)

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health? _____
_____

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

Medical History

Your current physical condition is:
Excellent Good Fair Poor

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
Please explain: _____
_____
_____

In the event of an emergency, who should we contact?
Name _____ Relation _____
Home # _____ Work # _____

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	Latex
Codeine	Nitrous Oxide
Darvon	Penicillin
Dental anesthetics	Percodan
Erythromycin	Tetracycline
Jewelry / Metal	Valium

Please list any drugs or materials that you are allergic to:
_____
_____

Have you ever had any of the following?

Abnormal bleeding	Hepatitis A, B, or C
Alcohol / Drug abuse	Herpes
Allergies (seasonal)	High Blood pressure
Anemia	HIV+ / AIDS
Arthritis	Kidney problems
Artificial Bones, joints, or valves	Liver disease
Asthma	Low blood pressure
Blood disease	Lupus
Blood transfusion	Mitral valve prolapse
Bruise easily	Nervousness / depression
Cancer / chemotherapy	Pacemaker
Colitis	Psychiatric condition
Congenital heart failure	Radiation treatment
Diabetes	Respiratory problems
Difficulty breathing	Rheumatic / scarlet fever
Dizziness	Seizures
Emphysema	Sickle cell disease
Epilepsy	Sinus problems
Fainting spells	Stomach problems
Frequent headaches	Stroke
Glaucoma	Thyroid problems
Heart attack	Tuberculosis (TB)
Heart murmur	Ulcers
Heart surgery	Venereal disease
Hemophilia	

Have you ever taken Phen-Fen? Yes No

For women only:
Are you taking birth control pills? Yes No
Are you pregnant? Yes No
Are you nursing? Yes No

Have you ever been hospitalized for any reason? Yes No
If yes, please explain: _____
_____
_____

Please list any other medical conditions you have had: _____
_____
_____
_____
_____

Disclaimer

I understand that the information I have given 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 of Blackfoot Smiles to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____
Signature Date

Cancellation Guidelines

When you make a dental appointment at Blackfoot Smiles, we have reserved that time specifically just for YOU, and no one else! If for some reason you are unable to come to your scheduled appointment, we would appreciate 48 hours notice. If you are not able to give 48 hours notice to reschedule your appointment, we ask that you make other arrangements and keep your scheduled appointment with us.

By signing here, I _____, show that I have read and will make every effort to adhere to the cancellation guidelines.

_____ _____
Patient signature Date

Thank you for helping us make our practice the best office in town, and a one-of-a-kind dental experience for you!

Blackfoot Smiles

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