summit dental

Patient Information:

Patient name: _____ Preferred Name: _____

Birth Date: _____ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y N

SS# (needed for insurance purposes): _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Work #: _____ Home #: _____

E-mail address: _____ Best way to reach you: _____

Do you prefer we contact you via phone, text message, or email?: _____

Employer: _____

Emergency Contact: _____ Phone: _____ Relationship to you: _____

Other family members seen by us: _____

How did you hear of us?: _____

If referred by someone, whom may we thank for the referral?: _____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient:_____

Birth Date: _____ SS# (needed for insurance purposes): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Dental Insurance Information (Primary):

Policyholder's Name: _____ Birth Date:_____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse: _____ Child: _____ Other: _____

Dental Insurance Information (Secondary):

Policyholder's Name: _____ Birth Date:_____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse: _____ Child: _____ Other: _____

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Dental History

On a Scale of 1-10, with 10 being the highest rating:

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

What, if anything, would you like to change about your smile?

☐Color ☐Bite ☐Chipped Teeth ☐Spaces ☐Crowding ☐Smile Makeover ☐Missing Teeth ☐Whiter Teeth

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? _____

_____

Please mark (X) next to any of the following conditions that apply to you

Appearance
__Discolored Teeth
__Worn Teeth
__Misshapen Teeth
__Crooked Teeth
__Spaces
__Overbite
__Flat Teeth

Pain/Discomfort
__Sensitivity (hot, cold, sweet)
__Pressure
__Broken Teeth/Fillings
__Dry Mouth

Function
__Grinding/Clenching
__Headaches
__Jaw Joint (TMJ) Pain/Noise
__Bad bite
__Sore Muscles (neck, shoulders)
__Difficulty Opening or Closing
__Difficulty Chewing on either side

Periodontal (Gum) Health
__Bleeding, Swollen, Irritated gums
__Bad Breath
__Loose, Tipped, Shifting teeth
__Previous Perio/Gum Disease

Sleep Pattern or Conditions
__Does anyone tell you that you snore
__Daytime Drowsiness
__Difficulty falling asleep
__Difficulty maintaining sleep
__Sleep Apnea
__ Nasal CPAP
__ Mouth CPAP

Child Sleep Pattern or Conditions
__Bed Wetting (for children)
__Mouth Breathing
__Snoring
__Daytime Sleepiness

Habits
__Thumb Sucking
__Nail-biting
__Cheek/Lip Biting
__Chewing on Ice/Foreign objects

Social History
__Tobacco
Cigarettes ___ Chew ___ Vape ___
How much ____ How long _____
Alcohol Frequency_____
__Recreational Drugs

Previous Comfort Options
__Nitrous Oxide
__Oral Sedation (Pill)
__IV Sedation

Please list family history of any conditions marked:_____
_____
_____
_____
_____

Medical History

Please mark (X) to indicate if you have or have had any of the following medical conditions

Cancer
__History of Cancer
If yes, Type:_____
Year:_____
__Chemotherapy
__Radiation Therapy

Cardiovascular
__Angina (chest pain)
__Artificial Heart valve
__Heart Attack
__Heart Conditions
__Heart Surgery
(Stents,Valves, etc)
__High Blood Pressure
__Low Blood Pressure
__Mitral Valve Prolapse
__Pacemaker
__Rheumatic Fever
__Scarlet Fever
__Stroke

Endocrinology
__Diabetes
__Hepatitis A/B/C
__Jaundice
__Kidney Disease
__Liver Disease
__Thyroid Disease

Gastrointestinal
__Ulcers (stomach)
__GERD/Acid Reflux
__Other GI disease

Hematologic/Lymphatic
__Anemia
__Blood Disorders
__Bruise Easily

__Excessive Bleeding

Musculoskeletal
__Arthritis
__Artificial Joints
If yes, year(s):_____
__Jaw Joint Pain
__Rheumatoid Arthritis

Neurological
__ADD/ADHD
__Anxiety
__Autism
__Depression
__Dizziness
__Drug/Alcohol Abuse
__Fainting
__Seizures
__Psychiatric Illness

Respiratory
__Asthma
__Emphysema
__COPD
__Sinus Problems
__Difficulty Breathing
__Tuberculosis

Viral Infections
__AIDS
__HIV Positive
__HPV

Women
__Currently Pregnant
If yes, due date: _____
__Nursing
__Taking Birth Control

Medication Allergies
__Amoxicillin
__Clindamycin
__Penicillin
__Sulfa Drugs
__Opioids(Percocet, oxycodone, Tylenol 3)
__Latex
__Local Anesthetics
__ NSAIDs
__Dairy products
__Other Allergies
If yes, please list_____
_____
_____
Additional comments:
_____
_____
_____

Are you currently under the care of a physician? Yes or No

If yes, please explain: _____

_____

Physician Name _____ Phone: (_____)_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, if yes please explain _____

_____

_____

Are you taking or have recently taken any prescription or over the counter medicine(s)? Yes or No

If yes, please list all and why including vitamins, natural or herbal supplements and/or dietary supplements _____

_____

Have you ever had surgery? If so, what type: _____

_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photograph, or any diagnostic aids deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand all treatment will be discussed with me prior to being rendered. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Signature of Patient/Legal guardian *Patient Name (printed)* *Date*

_____ _____

Signature of Dentist *Date*