SMILE SMILE SMILE

Piney Creek FAMILY DENTISTRY

Date_____

Patient Information:

Patient Name _____

Social Security: _____

Address _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

☐ Male ☐ Female Date of Birth _____

How did you hear about Piney Creek Family Dentistry?

☐ Referral _____

☐ Mailing ☐ Phone Book

☐ Newspaper Ad ☐ Building Sign

☐ Website ☐ Insurance Company

☐ Other _____

Primary Dental Insurance:

Subscriber Name_____

Relationship to Patient _____

Date of Birth _____ SS#/ID# _____

Address (if different from patient) _____

Subscriber's Employer _____

Insurance Company _____

Group # _____

Secondary Dental Insurance:

Subscriber Name_____

Relationship to patient_____

Date of birth_____ SS# / ID# _____

Address(if different from patient)_____

_____

Subscriber's Employer _____

Insurance Company_____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Piney Creek Family Dentistry and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Piney Creek Family Dentistry and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of patient or personal representative

_____
Print name of patient or personal representative

_____ _____
Date Relationship to patient

Contact Information:

Phone: Home_____ **Work**_____ **Cell** _____

E-Mail _____ **What's the best phone number & time of day to reach you?**_____

Emergency Contact Information:

Name: _____ **Phone # 1**_____ **Phone # 2** _____

Reason for today's visit: _____

Dental History:

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (Here or elsewhere)

- ☐ **Cost**
- ☐ **Fear of Pain**
- ☐ **No time**
- ☐ **No insurance**
- ☐ **Didn't hurt / didn't think I needed treatment**
- ☐ **Other (please explain)** _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

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

Please check all that apply:

- ☐ **Bad Breath**
- ☐ **Bleeding gums**
- ☐ **Blisters on lips or mouth**
- ☐ **Burning sensation on tongue**
- ☐ **Chew on one side of mouth**
- ☐ **Cigarette/pipe/cigar smoking**
- ☐ **Clicking or popping jaw**
- ☐ **Dry mouth**
- ☐ **Fingernail biting**
- ☐ **Food collection between teeth**
- ☐ **Foreign objects**
- ☐ **Grinding teeth**
- ☐ **Gums swollen or tender**
- ☐ **Jaw pain**
- ☐ **Jaw tiredness**
- ☐ **Lip or cheek biting**
- ☐ **Loose teeth/broken fillings**
- ☐ **Mouth breathing**
- ☐ **Mouth pain, brushing**
- ☐ **Orthodontic treatment**
- ☐ **Pain around ear**
- ☐ **Periodontal treatment**
- ☐ **Sensitivity to cold**
- ☐ **Sensitivity to heat**
- ☐ **Sensitivity to sweets**
- ☐ **Sensitivity when biting**
- ☐ **Sores/growths in mouth**

Health History:

Physician's Name: _____ Date of last visit:_____

Have you ever taken any medications containing bisphosphonates: This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia and Zometa. ☐ Yes ☐ No

Please check all that apply:

- ☐ **AIDS / HIV**
- ☐ **Anemia**
- ☐ **Arthritis, Rheumatism**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Back Problems**
- ☐ **Bleeding abnormally, with extractions or surgery**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Chemical Dependency**
- ☐ **Chemotherapy**
- ☐ **Circulatory Problems**
- ☐ **Congenital Heart Lesions**
- ☐ **Cortisone Treatments**
- ☐ **Cough, persistent / bloody**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Emphysema**
- ☐ **Epilepsy**
- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Headaches**
- ☐ **Heart Murmur**
- ☐ **Heart Problems**
- ☐ **Hepatitis Type ____**
- ☐ **Herpes**
- ☐ **High Blood Pressure**
- ☐ **Jaundice**
- ☐ **Jaw Pain**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Mitral Valve Prolapse**
- ☐ **Nervous Problems**
- ☐ **Pacemaker**
- ☐ **Psychiatric Care**
- ☐ **Radiation Treatment**
- ☐ **Respiratory Disease**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Shortness of Breath**
- ☐ **Sinus Trouble**
- ☐ **Skin Rash**
- ☐ **Special Diet**
- ☐ **Stroke**
- ☐ **Swollen Feet / Ankles**
- ☐ **Swollen Neck Glands**
- ☐ **Thyroid Problems**
- ☐ **Tonsillitis**
- ☐ **Tuberculosis**
- ☐ **Tumor or growth on head or neck**
- ☐ **Ulcer**
- ☐ **Venereal Disease**
- ☐ **Weight Loss / Gain**

Do you wear contact lenses? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing: ☐ Yes ☐ No

Medications:

List any medications you are currently taking and the Correlating diagnosis: _____

_____

Allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other_____

_____

CONSENT

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients 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 that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of child) _____Date _____ DENTIST Signature _____

SMILE SMILE SMILE

Piney Creek FAMILY DENTISTRY

SMILE EVALUATION FORM

WHAT **DON'T** YOU LIKE ABOUT YOUR TEETH?

(Please rank your concerns in order, with "1" being your "chief complaint")

_____ CROWDING / CROOKED TEETH

_____ SPACES

_____ TOOTH SHAPE

_____ TOOTH SIZE

_____ GUMMY SMILE

_____ UNDERBITE

_____ TEETH ARE DIFFERENT COLORS

_____ OTHER _____

_____ JAW JOINT PAIN

_____ MISSING TEETH

_____ DARK TEETH

_____ WORN DOWN TEETH

_____ OVERBITE

_____ FACIAL PROFILE

_____ UGLY OLD CROWNS

I AM INTERESTED IN:

_____ 6 MONTHS CLEAR BRACES

_____ TEETH WHITENING

_____ COSMETIC GUM LIFT

_____ OTHER _____

_____ INVISALIGN

_____ SNAP ON SMILE

_____ METAL-FREE CROWNS

_____ VENEERS

_____ LUMINEERS

IS THERE ANYTHING YOU WOULD LIKE THE DENTIST TO KNOW?

_____

_____