REVIVE
SMILES DENTISTRY

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Please Print

PATIENT INFORMATION

Patient _____ ❑ Male ❑ Female
Last First M.I.

By what name would you like us to address you? _____

Home # _____ Work # _____ Cell # _____

Email _____ Birthdate _____ Age _____ SS#_____

Address _____
Street City State Zip

Occupation _____ Employer _____

Spouse / Parent's Name _____ Occupation _____

Person responsible for account (if someone else) _____

Address _____
Street City State Zip

Home # _____ Work # _____ Cell # _____

Employer _____
Street City State Zip

In case of emergency call _____ Day Phone _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Employee Name _____ Employer _____

Name of Insurance Company _____ Policy # _____

Group # _____ Birthdate _____

Second Insurance (if applicable) _____

Employee Name _____ Employer _____

Name of Insurance Company _____ Policy # _____

Group # _____ Birthdate _____

Signature _____ ❑ Patient ❑ Parent/Gardian ❑ Spouse Date _____

DENTAL HISTORY

Previous Dentist _____ City _____

When was your last dental exam? _____

What is your immediate dental concern? _____

Please check yes or no if you have, or ever had the following:

	Yes	No		Yes	No
Unhappy with appearance of your teeth	❑	❑	Burning sensation in your mouth	❑	❑
Unfavorable dental experiences/dental fears	❑	❑	Difficulty swallowing	❑	❑
Prefer no dental anesthetic	❑	❑	An unpleasant taste or odor in your mouth	❑	❑
Problems with effectiveness or			Jaw problems (temporomandibular joint)	❑	❑
had reactions to dental anesthetic	❑	❑	Difficulty opening your mouth widely	❑	❑
Orthodontic treatment (braces) when _____	❑	❑	Stiff neck muscles	❑	❑
Periodontal (gum) treatment when _____	❑	❑	Awaken with an awareness of your teeth or jaws	❑	❑
Bleeding gums	❑	❑	Tension headaches	❑	❑
Avoid brushing any part of your mouth	❑	❑	Clench or grind your teeth	❑	❑
Part of your mouth is sensitive to temperature	❑	❑	Jaw clicking or popping	❑	❑
Sore teeth	❑	❑	Lost any teeth	❑	❑

Are you allergic to any of the following? Aspirin ❑ Penicillin ❑ Erythromycin ❑ Codeine ❑ Latex ❑

Local Anesthetic ❑ Fluoride ❑ Metals (gold, stainless steel) ❑ Other ❑ _____

MEDICAL HISTORY

Physician Name _____ Phone _____

Please check yes or no if you have, or ever had the following:

	Yes	No		Yes	No
Hospitalization for illness or injury	❑	❑	Head or neck injuries	❑	❑
Heart problems	❑	❑	Epilepsy, convulsions (seizures)	❑	❑
Heart murmur	❑	❑	Viral infections and cold sores	❑	❑
Rheumatic fever	❑	❑	Any lumps or swelling in the mouth	❑	❑
Scarlet fever	❑	❑	Hives, skin rash, hay fever	❑	❑
High blood pressure	❑	❑	Venereal disease	❑	❑
Low blood pressure	❑	❑	Hepatitis (type) _____	❑	❑
A stroke	❑	❑	AIDS / HIV Positive	❑	❑
Artificial prosthesis (i.e. heart valve or joints)	❑	❑	Tumor, abnormal growth	❑	❑
Anemia or other blood disorder	❑	❑	Radiation therapy	❑	❑
Prolonged bleeding	❑	❑	Chemotherapy	❑	❑
Emphysema	❑	❑	Emotional problems	❑	❑
Tuberculosis	❑	❑	Psychiatric treatment	❑	❑
Asthma	❑	❑	Antidepressant medication	❑	❑
Sinus problems	❑	❑	Alcohol / drug dependency	❑	❑
Diabetes	❑	❑	Presently treating for any illness _____	❑	❑
Kidney disease	❑	❑	Aware of a change in your general health	❑	❑
Liver disease	❑	❑	Often exhausted or fatigued	❑	❑
Jaundice	❑	❑	Subject to frequent headaches	❑	❑
Thyroid or parathyroid disease	❑	❑	Heavy smoker (1 pack or more per day)	❑	❑
Stomach or duodenal ulcer	❑	❑	Generally a nervous person	❑	❑
Arthritis	❑	❑	Often unhappy or depressed	❑	❑
Osteoporosis	❑	❑	FEMALE - Taking birth control pills	❑	❑
Glaucoma	❑	❑	FEMALE - Pregnant	❑	❑
Contact lenses	❑	❑	MALE - Prostate disorders	❑	❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List any medications taken within the last two years_____

Please advise us in the future of any changes in your medical history or medications you may be taking. In the event suit is necessary to collect any outstanding monies for services rendered, patient, parent or guardian agrees to pay attorney fees, collection fees, and court costs.

Signature _____ ❑ Patient ❑ Parent/Gardian ❑ Spouse Date _____

Dr. Signature _____ Date _____