**Welcome and Thank You for choosing Arnold Dental Arts, LLC!**

3901 Vogel Rd. Arnold, MO 63010-3798

[www.arnolddentalarts.com](http://www.arnolddentalarts.com)

Office: (636) 296-6885 Fax: (636) 296-3988

**Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| If the patient child or minor please check here |  | Parent Name |  |
|  |
| PATIENT NAME |  | SSN |  |
| ADDRESS |  | CITY/STATE/ZIP CODE |  |
| HOME PHONE |  | CELL PHONE |  |
| EMERGENCY |  | EMAIL ADDRESS |  |
| SEX |  | AGE |  |
| DATE OF BIRTH |  |  |  |

**CIRCLE ONE MARITAL STATUS**

SINGLE MARRIED DIVORCED WIDOWED SEPARATED

**CIRCLE ONE RACE**

CAUCASIAN BLACK ASIAN HISPANIC AMERICAN INDIAN MIXED

|  |  |  |  |
| --- | --- | --- | --- |
| EMPLOYER |  | OCCUPATION |  |
|  |
| BUSINESS ADDRESS |  | BUSINESS PHONE |  |

**REFERRED BY**

|  |  |  |  |
| --- | --- | --- | --- |
| IN CASE OF EMERGENCY:CONTACT |  | CONTACT PHONE |  |
|  |

**Dental History**

Reason for today’s visit

Previous dentist

Reason for the change

Date of last cleaning and exam Last x-rays

**Check if you HAVE or HAVE HAD problems with any of the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| * BAD BREATH
 | * GRINDING TEETH
 | * SENSTIVITY TO HOT
 | * SENSTIVITY TO COLD
 |
| * BLEEDING GUMS
 | * LOOSE TEETH
 | * BROKEN FILLINGS
 | * SENSIIVITY TO SWEETS
 |
| * POPPING JAW
 | * HEAD TRAUMA
 | * PERIODNTAL THERAPY
 | * SORES/ORAL GROWTHS
 |
| * NECK PAIN
 | * INJURY TO MOUTH
 | * SENSITIVITY TO BITING
 | * FOOD COLLECTING IN TEETH
 |

Have you ever had a problem with a tooth extraction?

How often do you BRUSH? FLOSS? WATER PIK? RINSE?

**Dental Survey**

SMILE EVALUATION

Are you happy with your smile?

If you answered no to the previous question, why?

How would you rate your smile? (1-Bad to 10-Great)

Do you feel that you try to hide your smile?

What do you believe needs improvement with your smile?

Do you want to change your smile?

Are you interested in cosmetic avenues for change?

GUM EVALUATION

Do your gums bleed?

When do they bleed?

Are your gums shrinking?

Are your teeth sensitive?

Are your teeth loose?

Do you have bad breath?

Do you have medical problems?

TMJ EVALUATION

Do you have headaches?

Do you have migraines?

Do you have ringing in the ears?

Do you have Vertigo/dizziness?

Do you have neck pain?

Do you have muscleaches?

Do your jaw joints click or pop?

Do you have pain in your jaw joints?

Do they lock?

Do you snore at night?

Do you grind your teeth at night?

Do you awaken rested or tired?

ANXIETY EVALUATION

Have you had good past experiences at the dentist?

If you answered no to the previous question, why?

Are you nervous about going to the dentist?

Are you so fearful that the idea of going to the dentist makes you physically ill?

Do you find ways to aviod going?

Are you interested in decreasing your anxiety or fear?

Would you like to have your work preformed and not remember the visit?

**Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| PRIMARY DOCTOR’S NAME |  | PHONE |  |
|  |
| DATE OF LAST VISIT |  | REASON |  |
| DATE OF LAST PHYSICAL |  | BLOOD TYPE |  |

Have you ever had any blood transfusions or received blood products?

**Allergies to medications**

**Other allergies**

Have you ever taken Fenfluramine and/or Dexfenfluramine (FEN-PHEN or REDUX)?

Are you allergic to latex? Have you ever taken Cortisone?

Do you drink alcoholic beverages? How often?

Do you smoke or use tobacco? How often?

Have you ever had radiation treatments? Where?

When? How much?

**WOMEN:**

Are you now or could be pregnant? Nursing?

Are you trying to get pregnant?

Are you taking birth control medication? Type?

**List Hospitaliztions** Date

 Date

**List Surgeries** Date

 Date

 Date

**Do you HAVE or HAVE HAD any of the following: (check all that apply)**

|  |  |  |
| --- | --- | --- |
| * ANEMIA
 | * BRONCHITIS
 | * MONONUCLEOSIS
 |
| * ARTHRITIS
 | * DIGESTIVE PROBLEMS
 | * MITRAL VALVE PROLAPSE
 |
| * OSTEOARTHRITIS
 | * HEADACHES
 | * ORGAN TRANSPLANT
 |
| * RHUEMATOID
 | * HYPERTHYROID
 | * PACEMAKER
 |
| * ARTIFICAL HEART VALVES
 | * HYPOTHYROID
 | * PSORIASIS
 |
| * ARTIFICIAL JOINTS
 | * HEAR MURMUR
 | * PSYCHIATRIC THERAPY
 |
| * ASTHMA
 | * HEART ATTACK
 | * RESPIRATORY DISEASE
 |
| * BACK PROBLEMS
 | * HEART PROBLEMS
 | * RHUEMATIC FEVER
 |
| * BLOOD DISEASES
 | * HEMOPHILIA
 | * RASH
 |
| * BLEEDING PROBLEMS
 | * HEPATITIS
 | * SCARLET FEVER
 |
| * BLADDER DISEASE
 | * A
 | * SICKLE CELL ANEMIA
 |
| * CANCER
 | * B
 | * SINUS PROBLEMS
 |
| * CHEMICAL DEPENDENCY
 | * C
 | * SKIN DISEASE
 |
| * CHEMOTHERAPY
 | * D
 | * STEROID TREATMENTS
 |
| * DIABETES
 | * CHEMICAL
 | * STROKE
 |
| * EPILEPSY
 | * HIGH BLOOD PRESSURE
 | * SWOLLEN JOINTS
 |
| * EMPHYSEMA
 | * HIV/AIDS
 | * SWOLLEN LIMBS
 |
| * EMOTIONAL PROBLEMS
 | * IRRITABLE BOWEL
 | * TIA
 |
| * ENDOCARDITIS
 | * KIDNEY DISEASE
 | * ULCERS
 |
| * FAINTING
 | * KIDNEY TRANSPLANT
 | * ULCERATIVE COLITIS
 |
| * GERD
 | * LIVER DISEASE
 | * VASCULAR/CIRCULATORY PROBLEMS
 |
| * GLAUCOMA
 | * LOW BLOOD PRESSURE
 | * VENEREAL DISEASE
 |
| * GASTRITIS
 | * LUPUS
 |  |

Do you have any other conditions not listed above?

**Medication History**

Medications you are currently taking:

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Supplements you are currently taking:

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

Homeopathics or herbals you are taking:

Name Dose Times/Day

Name Dose Times/Day

Name Dose Times/Day

**Authorization**

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence according to the current HIPPA laws that are in effect. It is **MY** responsibility to inform the office of any changes in the information concerning **MYSELF** or **MY CHILD** or **ANYONE ELSE** I am responsible for. I authorize the dentist and staff to perform the necessary dental services for **MYSELF**, **MY CHILD/MINOR**, or **OTHER INDIVIDUAL FOR WHOM I AM A GUARDIAN**.

I understand and that I am fully responsible for **ALL** charges whether or not I have dental benefits.

I authorize my medical or dental insurance benefit company to pay all insurance benefits directly to Arnold Dental Arts, LLC.

I authorize the use of my signature on all insurance submissions.

**Date:**