D A V I D L . T H O M A S , D M D
A GREAT SMILE AZ
2700 S. RURAL RD., TEMPE, AZ 85282
PH 480.967.9453
www.agreatsmileaz.com

PATIENT INFORMATION

Today's Date: _____ ☐ Male ☐ Female

Name: _____ DOB: _____

Address: _____
(Number and Street) (City) (State) (ZIP)

Phone: (_____)_____ (_____)_____ (_____)_____
(Home) (Work) (Cell)

Email: _____ SSN: _____

Spouse's Name: _____

Patient Occupation/School: _____ Grade: _____

Employer Name and Address: _____

Employer Phone: (_____)_____

How Did You Hear About Our Office? _____

PERSON RESPONSIBLE FOR THE ACCOUNT (if not patient)

Name: _____ DOB: _____

Address: _____
(Number and Street) (City) (State) (ZIP)

Phone: (_____)_____ (_____)_____ (_____)_____
(Home) (Work) (Cell)

Email: _____ Relationship to Patient: _____

Occupation: _____

Employer Name and Address: _____

Employer Phone: (_____)_____

EMERGENCY CONTACT INFORMATION

Name: _____ DOB: _____

Address: _____
(Number and Street) (City) (State) (ZIP)

Phone: (_____)_____ (_____)_____ (_____)_____
(Home) (Work) (Cell)

Email: _____ Relationship to Patient: _____

Do we have your permission to discuss treatment/condition with this person in the event that they need to be contacted? **(Required)**

☐ YES ☐ NO Signature: _____

BILLING AND INSURANCE INFORMATION

Are you currently enrolled in a dental insurance program? ☐ YES ☐ NO

Primary Dental Insurance:

Company: _____ Phone: (_____)_____

Policy Number: _____ ID#:_____

Group Number: _____

Insured's Employer: _____

Insured's Name (as it appears on card): _____

Relationship to Patient: _____

Insured's Address: _____
(Number and Street) (City) (State) (ZIP)

Insured's Phone: (_____)_____

Insured's DOB: _____ Insured's SSN: _____

I authorize payment of insurance benefits directly to the dentist of record.

Signature: _____ Date: _____

I authorize the release of any necessary medical information to my insurance company.

Signature: _____ Date: _____

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough 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 in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine.

Patient Signature: _____ Date: _____

Parent or Responsible Party Name: _____ Date: _____

Parent or Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

PATIENT MEDICAL HISTORY

Are you generally in good health? ☐ YES ☐ NO

If NO, explain _____

Have you ever had to take medication before seeing a dentist? ☐ YES ☐ NO

If YES, explain _____

Are you currently taking any **blood thinners**? ☐ YES ☐ NO

What **medications** are you currently taking?

Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____

Are you **allergic** to any of the following?

Latex	☐ YES	☐ NO	Aspirin	☐ YES	☐ NO
Local anesthetics	☐ YES	☐ NO	Sulfa	☐ YES	☐ NO
Codeine	☐ YES	☐ NO	Iodine	☐ YES	☐ NO
Antibiotics (e.g., amoxicillin)	☐ YES	☐ NO	Barbiturates (sleeping pills)	☐ YES	☐ NO

If YES to any Antibiotics, which one(s): _____

Do you have any other **allergies**?

Name: _____ Reaction: _____
Name: _____ Reaction: _____

Have you had any joint replacements or implants? ☐ YES ☐ NO

If YES, What _____ When (year) _____

Have you had a heart valve replacement or any other heart surgery? ☐ YES ☐ NO

If YES, What _____ When (year) _____

Primary Care Physician:

Name: _____ Phone: (_____)_____

Have you ever had any of the following? (check all that apply)

☐ Alcoholism	☐ Depression	☐ Joint disorder	☐ Sinus problems
☐ Allergies	☐ Dizzy spells	☐ Kidney disorder	☐ Skin disorder
☐ Anemia	☐ Eating disorder	☐ Liver disorder	☐ Stroke
☐ Anxiety disorder	☐ Epilepsy	☐ Lung disease	☐ Stomach ulcer
☐ Arthritis	☐ Fainting	☐ Lupus	☐ Substance abuse
☐ Asthma	☐ Hay fever	☐ Measles	☐ Thyroid disorder
☐ Bleeding disorder	☐ Head injury	☐ Migraines	☐ Tuberculosis
☐ Blood disease	☐ Heart disease	☐ Mitral valve prolapse	☐ Tumors or growth
☐ Blood transfusion	☐ Heart problems	☐ Osteoporosis	☐ Venereal disease
☐ Bowel disorder	☐ Hepatitis-A, B or C	☐ Pacemaker	
☐ Cancer	☐ High blood pressure	☐ Radiation treatment	
☐ Diabetes	☐ High cholesterol	☐ Rheumatic fever	

Have you ever had trouble with prolonged bleeding? ☐ YES ☐ NO

Have you ever been tested for the AIDS virus? ☐ YES ☐ NO

If Yes, result _____

Do you currently smoke? ☐ YES ☐ NO Have you ever smoked? ☐ YES ☐ NO

PATIENT DENTAL HISTORY

What brings you to the office today? _____

Are you having pain at this time? _____

When was your last dental visit? _____

When was your last dental cleaning? _____

When were your last dental x-rays taken? _____

How often do you brush? _____ times a day/week How often do you floss? _____ times a day/week

Do you grind your teeth? ☐ YES ☐ NO

Have you ever had orthodontic (braces) treatment? ☐ YES ☐ NO

Have you ever had periodontal (gum) treatment? ☐ YES ☐ NO

Have you ever had oral surgery (other than wisdom teeth removal)? ☐ YES ☐ NO

Have you ever worn a bite plate or other appliance? ☐ YES ☐ NO

Do you have any of the following? (check all that apply)

☐ Bad breath	☐ Difficulty opening or closing	☐ Loose teeth	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Dry mouth	☐ Mouth pain	☐ Sensitivity to pressure
☐ Blisters on mouth	☐ Difficulty chewing	☐ Mouth sores	☐ Swollen gums
☐ Broken fillings	☐ Ear pain	☐ Sensitivity to cold	
☐ Clicking jaw	☐ Jaw pain	☐ Sensitivity to heat	

What do you like about your smile? _____

What don't you like about your smile? _____

Is there anything you would like to change about your smile? _____

On a scale of 1 to 10 (1 = not at all, 10 = extremely important), please rate the following:

How important is it for you to keep your natural teeth for as long as possible? (1 2 3 4 5 6 7 8 9 10)

How important is it that your breath be as clean and fresh as possible? (1 2 3 4 5 6 7 8 9 10)

On a scale of 1 to 10 (1 = not at all, 10 = very healthy), please rate the following:

How healthy do you want your teeth and gums to be? (1 2 3 4 5 6 7 8 9 10)

How healthy do you think your teeth and gums currently are? (1 2 3 4 5 6 7 8 9 10)

On a scale of 1 to 10 (1 = not at all or none, 10 = a lot or all the time), please rate the following:

When you brush and floss, how much bleeding do you currently have? (1 2 3 4 5 6 7 8 9 10)

How much bleeding do you think should be considered "normal" when brushing and flossing? (1 2 3 4 5 6 7 8 9 10)