# Welcome.

Life gets better with each smile.

AestheticDentistry
OF STUART

*Please take a few minutes to answer the following questions so we can better assist you.*

## GUEST INFORMATION

TODAY'S DATE _____ DATE OF BIRTH _____

*(guest)* LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____ ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ WIDOWED

HOME PHONE _____ CELL PHONE _____

EMAIL _____ EMPLOYER _____

WHOM MAY WE THAN FOR REFERRING YOU TO US? _____

**In case of emergency contact:**

NAME _____ RELATIONSHIP _____

EMERGENCY HOME PHONE _____ EMERGENCY CELL PHONE _____

## PRIMARY DENTAL INSURANCE *(or provide copy of ID card)*

*(individual responsible for this account)* LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO GUEST _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

RESPONSIBLE PARTY EMPLOYED BY _____

INSURANCE COMPANY _____ INSURANCE COMPANY ADDRESS *and* PHONE _____

SUBSCRIBER ID # _____ GROUP # _____

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**Check any symptom(s) or condition(s) below that you currently have or have had in the past.**

### HEART
- ☐ Artificial heart valve
- ☐ Cardiac pacemaker
- ☐ Cardiovascular disease
- ☐ Heart attack
- ☐ Stroke
- ☐ Angina (chest pain)
- ☐ Congenital or heart disease
- ☐ High blood pressure
- ☐ Low blood pressure

### NEUROLOGICAL
- ☐ Parkinson's/MS
- ☐ Epilepsy/seizure
- ☐ Dementia/Alzheimer's
- ☐ Depression/anxiety
- ☐ Vertigo
- ☐ Psychiatric disorder
- ☐ Bleeding disorder (anemia,hemophilia, etc)
- ☐ History of drug or alcohol abuse
- ☐ Headaches or migraines

### JOINT
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ TMJ or TMD

### ENDOCRINE
- ☐ Diabetes
- ☐ Low blood sugar
- ☐ Thyroid disease

### SENSORY
- ☐ Eye disease
- ☐ Glaucoma
- ☐ Hearing loss

### RESPIRATORY
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Bronchitis/chronic cough
- ☐ Asthma
- ☐ Sinus problems/hay fever

### GASTROINTESTINAL
- ☐ Stomach ulcers
- ☐ GERD or reflux
- ☐ Jaundice
- ☐ Hepatitis (type: _____ )
- ☐ Kidney disease
- ☐ Liver disease

### INFECTION
- ☐ HIV/Aids
- ☐ Herpes/cold sores
- ☐ Cancer (list type)

_____

Are there any conditions not listed above that are relevant? ☐ YES ☐ NO

If you answered yes to any of the above conditions please give a brief explanation:

_____

## QUESTIONS

1. Have you ever been advised to take antibiotic premedication prior to routine dental work? ☐ YES ☐ NO

   If yes, give reason and antibiotic used: _____

2. Have you ever had surgery and/or radiation for a tumor or growth in the head or neck region? ☐ YES ☐ NO

   If yes, please give surgery/date: _____

3. Have you ever had abnormal bleeding following extractions or surgery? ☐ YES ☐ NO

   If yes, briefly explain why (ie: blood thinners): _____

4. Are you currently taking or have you taken bisphosphonate (bone density) medications such as Actonel, Reclast, or Fosamax within the past twelve years? ☐ YES ☐ NO

   If yes, please list drug name and dates taken: _____

5. Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment: _____

   _____

6. Do you have any other significant medical history that you would like to discuss with the doctor in private?

   ☐ YES ☐ NO

*Questions continue on next page*

## WOMEN ONLY

Is there a possibility that you are pregnant? ☐ YES ☐ NO Expected Due Date: _____

## ALLERGIES

☐ None

☐ Penicillin ☐ Aspirin ☐ Latex ☐ Codeine ☐ NSAIDs (Advil, Aleve, etc.) ☐ Dental Anesthesia

☐ Other (please list): _____

## MEDICATIONS

Are you currently taking any medications? ☐ YES ☐ NO

If yes, please give reasons for taking (or attach list): _____

_____

_____ _____

**Signature** **Date**