Ardent Dental
FAMILY DENTISTRY

Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip Code: _____

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

DOB:_____ SS#_____

Email Address:_____

☐Married (Spouse)_____ ☐Single ☐Divorced ☐Widow/er

Employer:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone Number(s): _____

Person Responsible for Payment of Account: _____

Mailing Address:_____

City:_____ State:_____ Zip Code: _____

Whom may we thank for referring you to our practice? _____

Insurance Company:_____

Group Number:_____

Employer's Name:_____

Insured's Name:_____

Date of Birth:___/_____/____ SS#_____ Relationship:_____

Insured's ID # _____

AUTHORIZATION: I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand I am responsible for all charges for dental services and materials not paid by my dental benefit plan. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Name:_____Date:_____

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Medical History

1. Have you been under the care of a medical doctor during the past two years? ❒ Yes ❒ No
   If yes, for what? _____
   Physician's Name:_____Phone: _____
   Address: _____City: _____ State:_____
2. Have you taken any medication or drugs during the past two years? ❒ Yes ❒ No
3. Are you taking any medication, drugs, or pills now? ❒ Yes ❒ No
   If yes, please list name and dosage:_____
4. Have you ever taken prescription medication for weight loss (diet pills)? ❒ Yes ❒ No
   If yes, did you take any of the following: ❒ Yes ❒ No Fen-Phen (fenfluramine-phenpermine)
   ❒ Yes ❒ No Pondimen (fenfluramine)
   ❒ Yes ❒ No Redux (dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart disease? _____
5. Have you had an allergic/adverse reaction to any medication or substance? ❒ Yes ❒ No
   If yes, please list:_____
6. Have you been a patient in the hospital during the past five years? ❒ Yes ❒ No
7. Indicate which of the following you have had, or have at present. Check "Yes" or "No"

Heart (surgery, disease, attack)	❒ Yes ❒ No	Ulcers	❒ Yes ❒ No
Chest Pain	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No
Congenital Heart Disease	❒ Yes ❒ No	Thyroid Problems	❒ Yes ❒ No
Heart Murmur	❒ Yes ❒ No	Glaucoma	❒ Yes ❒ No
High Blood Pressure	❒ Yes ❒ No	Contact Lenses	❒ Yes ❒ No
Mitral Valve Prolapse	❒ Yes ❒ No	Emphysema	❒ Yes ❒ No
Artificial Heart Valve	❒ Yes ❒ No	Chronic Cough	❒ Yes ❒ No
Heart Pacemaker	❒ Yes ❒ No	Tuberculosis	❒ Yes ❒ No
Rheumatic Fever	❒ Yes ❒ No	Asthma	❒ Yes ❒ No
Arthritis/Rheumatism	❒ Yes ❒ No	Hay Fever	❒ Yes ❒ No
Cortisone Medicine	❒ Yes ❒ No	Latex Sensitivity	❒ Yes ❒ No
Swollen Ankles	❒ Yes ❒ No	Allergies or Hives	❒ Yes ❒ No
Stroke	❒ Yes ❒ No	Sinus Trouble	❒ Yes ❒ No
Diet (Special/Restriction)	❒ Yes ❒ No	Radiation Therapy	❒ Yes ❒ No
Artificial Joints (hip, knee)	❒ Yes ❒ No	Chemotherapy	❒ Yes ❒ No
Kidney Trouble	❒ Yes ❒ No	Tumors	❒ Yes ❒ No
Hepatitis A/B	❒ Yes ❒ No	Venereal Disease	❒ Yes ❒ No
AIDS	❒ Yes ❒ No	HIV Positive	❒ Yes ❒ No
Cold Sores/Fever Blisters	❒ Yes ❒ No	Blood Transfusion	❒ Yes ❒ No
Hemophilia	❒ Yes ❒ No	Sickle Cell Disease	❒ Yes ❒ No
Bruise Easily	❒ Yes ❒ No	Liver Disease	❒ Yes ❒ No
Yellow Jaundice	❒ Yes ❒ No	Neurological Disorders	❒ Yes ❒ No
Epilepsy or Seizures	❒ Yes ❒ No	Fainting or Dizzy Spells	❒ Yes ❒ No
Nervous/Anxious	❒ Yes ❒ No	Psychiatric/Psychological	❒ Yes ❒ No

8. Do you have or have you had any disease, condition, or problem not listed? ❒ Yes ❒ No
   If yes, please list:_____
9. Pregnant? ❒ Yes: Months?____ ❒ No Nursing? ❒ Yes ❒ No Birth control pills? ❒ Yes ❒ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____ Date_____

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Patient Name:_____

What is the reason for your visit today? _____

Date of Last Dental Visit: _____ Date of Last Cleaning:_____

What was done at your last dental visit?_____

Previous Dentist's Name: _____

HIPPA regulations requires you (the patient) to contact your previous Dentist to release your x-rays

How often do you have dental examinations? _____

How often do you brush your teeth?_____How often do you floss? _____

What other dental aids do you use? (Rotodent, toothpick, etc.)_____

Do you currently have any dental problems? _____

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? ❒ Yes ❒ No
Sweets? ❒ Yes ❒ No
Biting or Chewing? ❒ Yes ❒ No

Do you:

Notice any bad tastes or mouth odors? ❒ Yes ❒ No
Frequently get cold sores, blisters, or any other oral lesions? ❒ Yes ❒ No

Do your gums bleed or hurt?

Any gum disease in family? ❒ Yes ❒ No
Tooth loss? ❒ Yes ❒ No
Have you noticed any loose teeth? ❒ Yes ❒ No
Have you noticed a change in bite? ❒ Yes ❒ No
Does food get caught in your teeth? ❒ Yes ❒ No
If yes, where? _____

Do you:

Clench or grind your teeth? ❒ Yes ❒ No
Bite your lips or cheeks regularly? ❒ Yes ❒ No
Hold foreign objects with your teeth? (i.e. pencils, pipe, pins, nails, fingernails, etc.) ❒ Yes ❒ No
Breathe through mouth? ❒ Yes ❒ No
Have tired jaws, especially in AM? ❒ Yes ❒ No
Smoke or chew tobacco? ❒ Yes ❒ No

Have you ever had:

Orthodontic treatment? ❒ Yes ❒ No
Oral surgery? ❒ Yes ❒ No
Periodontal treatment? ❒ Yes ❒ No
Your teeth ground or your bite adjusted? ❒ Yes ❒ No
A bite plate or mouth guard? ❒ Yes ❒ No
A serious injury to the mouth or head? ❒ Yes ❒ No
If so, please describe (including cause):
_____

Have you noticed or experienced?

Clicking/popping of the jaw? ❒ Yes ❒ No
Pain? (joint, ear, side of face) ❒ Yes ❒ No
Difficulty opening or closing mouth? ❒ Yes ❒ No
Difficulty chewing on either side? ❒ Yes ❒ No
Headaches/shoulder aches? ❒ Yes ❒ No
Sore muscles? ❒ Yes ❒ No

Satisfied with your teeth's appearance? ❒ Yes ❒ No

Do you feel nervous about treatment? ❒ Yes ❒ No
If so, what is your biggest concern?

Is there anything else about having dental treatment that you would like us to know?

_____

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Smile Evaluation

Patient Name:_____

We would like to help you obtain the smile you have always wanted. Please take a few minutes to complete this short Smile Evaluation.

1. Are you pleased with the appearance of your teeth when you smile?
   _____
2. Do you have any concerns about bad breath?
   _____
3. Are there spaces between your teeth that you do not like?
   _____
4. Are you pleased with the color of your teeth?
   _____
5. Are you pleased with the shape of your teeth?
   _____
6. Are your teeth:
   Chipped?____ Protruding?_____ Hidden?____ Crowded?____
7. Do you like the way your teeth fit together when you bite?
   _____
8. Are there old fillings or dental treatments that you are not happy with?
   _____
9. What would you change (if anything) about your smile?
   _____
10. Would you like to see how your smile could look different?
    _____