



Welcome to our practice. We look forward to providing you with excellent care in dentistry and facial aesthetics. Please fill out the following information so we may best serve you.

Dr. Lital Kathein • Dr. Jessica Wyatt • Dr. Jack Behn

PATIENT INFORMATION

TODAY'S DATE: ___/___/___
FIRST NAME: _____ LAST NAME: _____
HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____
AGE: _____ DATE OF BIRTH (mm/dd/yy): ___/___/___ SEX: M F
MARITAL STATUS: Single Married SOCIAL SECURITY #: _____ - _____ - _____
EMAIL ADDRESS (For our office use only): _____
HOME PH #: (_____) _____ CELL PH #: (_____) _____ WORK PH #: (_____) _____
EMPLOYER: _____ OCCUPATION: _____
WORK ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

HOW DID YOU HEAR ABOUT US? REFERRAL: Who may we thank for recommending us? _____
ONLINE: google facebook other online source: _____
EVENT: seminar bridal show spa event school event
MAILING: magazine postcard

EMERGENCY CONTACT

NAME OF PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: _____
RELATIONSHIP: _____ HOME PH #: (_____) _____ CELL PH #: (_____) _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT SELF PARENT/GUARDIAN OTHER _____
BILLING ADDRESS (if different from patient's address) _____
CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____
DENTAL INSURANCE? Y N INSURANCE COMPANY: _____ PHONE #: _____
NAME OF INSURED: SELF OTHER _____
RELATIONSHIP: _____ DATE OF BIRTH (mm/dd/yy): _____
SOCIAL SECURITY #: _____ - _____ - _____

YOUR MEDICAL INFORMATION

Name of primary doctor: _____ Phone number: _____

Are you under a physician's care for any medical condition? Y N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____

PLEASE LIST ALL THE **MEDICATIONS, PILLS, OR DRUGS THAT YOU ARE TAKING:** _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa drugs Local Anesthetics

Other allergies _____

Have taken Phen-Fen or Redux? Y N Have you taken Fosamax, Boniva, or Actonel? Y N

Do you drink alcohol? Y N If yes, how much/how often? _____

Do you smoke or use tobacco? Y N If yes, how much/how often? _____

WOMEN ONLY: Are you pregnant or trying to get pregnant? Y N If pregnant, how many weeks? _____

Are you taking oral contraceptives? Y N Are you nursing? Y N

In order to safely treat you and make proper diagnoses, it is important that we know your medical conditions.

Do you have, or have you had, any of the following?

| | | | | | | | |
|---------------------------|---|-----------------------|---|-----------------------|---|---------------------|---|
| AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N | Cortisone Medicine | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis A | <input type="checkbox"/> Y <input type="checkbox"/> N | Renal Dialysis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Alzheimer's Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis B or C | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N | Drug Addiction | <input type="checkbox"/> Y <input type="checkbox"/> N | Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Easily Winded | <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Press. | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet Fever | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Angina | <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N | High Cholesterol | <input type="checkbox"/> Y <input type="checkbox"/> N | Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis/Gout | <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy or Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N | Hives or Rash | <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N | Excessive Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N | Hypoglycemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Trouble | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Joint | <input type="checkbox"/> Y <input type="checkbox"/> N | Excessive Thirst | <input type="checkbox"/> Y <input type="checkbox"/> N | Irregular Heartbeat | <input type="checkbox"/> Y <input type="checkbox"/> N | Spina Bifida | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Fainting/Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Stomach/GI Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent Cough | <input type="checkbox"/> Y <input type="checkbox"/> N | Leukemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent Diarrhea | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Swelling of Limbs | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Breathing Problem | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N | Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bruise Easily | <input type="checkbox"/> Y <input type="checkbox"/> N | Genital Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N | Lung Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Tonsillitis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N | Osteoporosis | <input type="checkbox"/> Y <input type="checkbox"/> N | Tumors of Growth | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chest Pain | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Attack/Failure | <input type="checkbox"/> Y <input type="checkbox"/> N | Pain in Jaw Joints | <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcers | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cold Sores/Fever Blister | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | Parathyroid Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Congenital Heart Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Pace Maker | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Care | <input type="checkbox"/> Y <input type="checkbox"/> N | Yellow Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Convulsions | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Trouble/Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Radiation Treatments | <input type="checkbox"/> Y <input type="checkbox"/> N | | |

Have you ever had any serious illness not listed above? Y N If yes, please explain: _____

Do you need to be premedicated before dental treatment? Y N If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to the health of the patient. It is my responsibility to inform this office of any changes in my medical status.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: ____/____/____

PLEASE TELL US ABOUT YOUR SMILE

What is the primary reason for your visit today? _____

When was your last dental cleaning? _____ When was your last dental x-ray? _____

Do you brush regularly? Y N

Do you floss regularly? Y N

Have you had a bad reaction at the dentist in the past? Y N If yes, to what? _____

Your anxiety level at the dentist is: Low Medium High Very high

How happy are you with your smile? Very happy It's just OK Could be nicer

Please answer every question below:

Do your gums bleed when brushing/flossing? Y N

Are you currently experiencing dental pain? Y N

Do you grind or clench your teeth? Y N

Do you currently wear a nightguard when you sleep? Y N

Do you get frequent headaches? Y N

Do you suffer from TMJ symptoms or pain? Y N

Are you interested in implants to replace missing teeth? Y N

Are you interested in whitening your teeth? Y N

Are you interested in straightening your teeth? Y N

Are you interested in fuller lips? Y N

Are you interested in improving the lines/wrinkles around your mouth? Y N

Is there something about your smile that you would like to improve? _____

Comments:

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I acknowledge that all the information contained herein is true and correct and give my permission to verify any of the information provided. I, the undersigned (patient or legally responsible party), have reviewed the HIPAA Privacy Policy Notice available in the office of Elite Dental & Aesthetics.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: ____/____/____