FIBONACCI SMILE
Dr. Doug Milner & Dr. Cameron Alexander
One Fifth Street, Suite 100
Wenatchee, WA 98801
www.Fibonaccismile.com
(509) 665-0300

CLIENT INFORMATION

Name: _____ Date: _____
Last First MI Preferred Name

Gender: M F Date of Birth: _____Social Security #:_____

Address: _____ City: _____ State: _____ Zip code: _____

Phone #'s: Home_____ Work_____ Ext_____ Cell_____

E-Mail Address: _____

Employer: _____ Occupation/Department: _____ Phone # _____

Who may we contact in an emergency: _____ Phone # _____

Who referred you and/or how did you hear about our practice? _____

DENTAL INSURANCE INFORMATION

Primary

Name of Insured: _____

Insured's Birth Date: _____ SS#:_____

Ins Company Name: _____

Group/Policy #: _____

Subscriber ID#: _____

Relationship to Insured: ___ Self ___ Spouse ___ Child

Secondary

Name of Insured: _____

Insured's Birth Date: _____ SS#:_____

Ins Company Name: #:_____

Group/Policy #: _____

Subscriber ID#: _____

Relationship to Insured: ___ Self ___ Spouse ___ Child

PATIENT ACKNOWLEDGMENTS

- I understand that I am financially responsible for my own account and that all charges incurred are payable as outlined in the Financial Guidelines.
- I consent to the recording of videos, taking of radiographs and/or photographs before, during and after treatment for diagnostic purposes and for the use in scientific and educational papers or demonstrations.
- I certify that I have read (or had read to me), and understand and agree to the contents of this form.

_____ _____

PATIENT SIGNATURE (If under 18 years old, parent or guardian must sign) ***Date***

DENTAL HISTORY

To ensure your well-being while undergoing treatment in our office, please answer the following questions in detail

Name _____Date of Birth_____

Does dental treatment make you nervous? (Please circle) No Slightly Moderately Extremely

Have you ever had any serious trouble associated with any dental experience? YES NO
If yes, please explain:_____

Do you use the following?	Toothbrush	YES	NO	How often? _____
	Dental floss	YES	NO	How often?_____
	Other oral hygiene device	YES	NO	What and how often? _____

On a scale of 1 – 10 (1 being terrible, 10 being perfect) how healthy do you think your mouth is? _____

On a scale of 1 – 10 (1 being terrible, 10 being perfect) how healthy would you like your mouth to be? _____

Do you expect to keep your teeth for the rest of your life? YES NO

Are you happy with the appearance of your teeth? YES NO

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Orthodontic treatment (braces)	YES	NO	Loose teeth	YES	NO
Clicking/popping jaw	YES	NO	Periodontal/Gum disease	YES	NO
Clenching or grinding	YES	NO	Teeth sensitive to hot, cold, sweet	YES	NO
Shift or change in bite	YES	NO	Teeth sensitive to chewing	YES	NO
Unpleasant taste or bad breath	YES	NO			

What are some questions about dentistry and your oral health that you have never had adequately answered?

_____

_____

MEDICAL HISTORY

Physician's name:_____ Last physical exam;_____

Have you been hospitalized or had a serious illness within the last year? YES NO

If yes, please explain_____

Have you been advised to take antibiotics before a dental appointment? YES NO

If yes, please explain _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Jaw Joint Pain	YES	NO	Impaired Eyesight/Glaucoma	YES	NO
Arthritis	YES	NO	Hearing Aid/Hearing Disorder	YES	NO
Severe Headaches/Migraines	YES	NO	Kidney Condition: Shunt/ Dialysis	YES	NO
Epilepsy/seizures	YES	NO	Frequent Mouth Sores or Lesions	YES	NO
Ulcers	YES	NO	Positive HIV; AIDS ;AIDS related complex	YES	NO
Osteoporosis/osteopenia	YES	NO	Autoimmune disorder	YES	NO
Organ transplant	YES	NO	Parkinson's Disease	YES	NO
Depression/Anxiety	YES	NO	Drug/Alcohol addiction	YES	NO
			Steroid (prednisone cortisone) Therapy	YES	NO

Artificial Joint(s) YES NO If yes, which joint(s):_____Date of Replacement(s)?_____
Liver Condition YES NO If yes, Indicate condition (circle) Jaundice; Cirrhosis; Hepatitis Type A, Type B, Type C, Non-specific
Sleep Apnea YES NO If yes, are you using a C-Pap machine YES NO
Cancer YES NO If yes, type:_____ Treatment (circle all that apply) Surgical Chemo Radiation

ENDOCRINE:

Thyroid Disease YES NO

Diabetes YES NO

If yes, complete the following: Your last Hemoglobin A1c:_____

(circle) Type I Type II How often do you have HbA1c tested? 3mo 6mo 12mo

Do you require Insulin? YES NO How often do you check your blood sugar?_____

CIRCULATION:

Arterio/atherosclerosis	YES	NO	Heart Surgery: (circle) Bipass, Valve, Other	YES	NO
High Cholesterol	YES	NO	Rheumatic Fever; Rheumatic Heart Disease	YES	NO
High/Low Blood Pressure	YES	NO	Pacemaker If yes, date placed:_____	YES	NO
Mitral Valve Prolapse	YES	NO	Heart Attack(s) If yes, date:_____	YES	NO
Heart Murmur	YES	NO	Stroke	YES	NO
Angina (chest pain)	YES	NO	Blood/Bleeding disorder	YES	NO
Congestive Heart Failure	YES	NO	Congenital Heart Defect	YES	NO

RESPIRATORY:

Chronic Lung Disease	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Ever Exposed to TB	YES	NO
HayFever/Allergies	YES	NO	Persistent Cough or Cough up Blood	YES	NO
Emphysema	YES	NO	Chronic Sinus	YES	NO

Current Use of Tobacco YES NO If yes, type: (circle)

Cigarettes Marijuana Vape Snuff/Chew Cigar Pipe How much per day_____ Years of Use_____

Past History of Tobacco Use? YES NO If yes, date quit _____

ALLERGIES:

Are you allergic to or had previous reactions to the following: **(**Circle any/all that apply**)**

Aspirin Penicillin Tetracycline Erythromycin Sulfa Latex Codeine Barbiturates Tranquilizers

Dental anesthetic Other:_____

Have you ever had an adverse reaction (nausea, dizziness, hives, rash, difficulty breathing, etc.) with any medicine? YES NO

If yes, please explain_____

Do you have any medical problem condition not listed that you feel we should know about? YES NO

If yes, please explain_____

Women Only:

Are you currently pregnant: YES NO If yes, expected delivery date:_____

Are you nursing: YES NO Are you going or gone through menopause YES NO

Are you currently receiving **intravenous** Bisphosphonates? YES NO

If yes, for how long:_____

Are you currently taking **oral** Bisphosphonates (Fosamax, Actonel, Boniva)? YES NO

If yes for how long:_____

Have you been treated with this type of medication in the past? YES NO

MEDICATIONS: Please list all prescription medications, herbal medications, vitamins or supplements you are taking:

Name of medication Dosage Condition/reason for taking

_____

_____

_____

SIGNATURE: _____ ***DATE:*** _____