FIBONACCI SMILE
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CLIENT INFORMATION

Name: _____ Date: _____
Last First MI Preferred Name

Gender: M F Married/Domestic Partner Y N Date of Birth: _____Social Security#:_____

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

Phone #'s: Main Contact_____ Work_____ Add Number_____

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 Frequency? _____
Dental floss YES NO Frequency? _____
Other (WaterPik,SonicCare, etc.) YES NO What type/frequency? _____

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

On a scale of 1 – 10 (1 being terrible, 10 being excellent) 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? (Mark One)

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	Glaucoma	YES	NO
Arthritis	YES	NO	Hearing Aids	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	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

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: (Circle all that apply)

Thyroid Disease YES NO
Diabetes YES NO
If yes, complete the following:
Type I Type II
Do you require Insulin? YES

Last Hemoglobin A1c:_____
How often do you have HbA1c tested? 3mo - 6mo - 12mo
How often do you check your blood sugar?_____

CIRCULATION: (Circle all that apply)

Arterio/atherosclerosis	YES	NO	Heart Surgery: (circle) Bypass – Valve - Other	YES	NO
High Cholesterol	YES	NO	Rheumatic Fever; Rheumatic Heart Disease	YES	NO
High Blood Pressure	YES	NO			
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 and of the following: (Circle all that apply)
Cigarettes Marijuana Vape Chew/Snuff Cigar Pipe Per day_____Years of Use_____

Do you have a history of Tobacco Use? NO YES If yes, date quit _____

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

Aspirin Penicillin Tetracycline Erythromycin Sulfa Latex Codeine Barbiturates Tranquilizers

Dental anesthetic Gluten or Celiac Disease Other:_____

Have you ever had an adverse reaction to any medications? Please explain: _____

Do you have any medical problem condition not listed that you feel we should know about?
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 or provide a list of all prescription medications, herbal supplements, and vitamins you are taking as well as the dosage and reason for taking:

_____

_____

Signature: _____ ***DATE:*** _____