

smile

Welcome to Dentition, Atlanta's Center for Dental Artistry. We're pleased to have you as a client and want to assure you that we intend to do everything possible to ensure your comfort and confidence in our services. We strive to provide the highest quality care using only the very best techniques and materials – while catering to your ultimate relaxation in a pampering, nurturing environment. Please take a few minutes to complete the following profile. This information is required and will be considered strictly confidential.

about you

first name middle initial last name i prefer to be called

date birthdate age social security # email address

male female single married divorced widowed separated

city state zip code

home phone cell phone / other work phone ext. direct line

employer occupation how long there

employer's address

how did you hear about us whom may we thank and reward for referring you

your dental appearance

are you delighted with your smile yes no what would you change rate your smile from 1 to 10 (10=awesome)

would you like to have whiter teeth yes no what personal/professional benefit might you gain with a perfect smile

do you need dental work completed in time for an upcoming special occasion (please explain)

Through state-of-the-art technology, we have the ability to help you achieve a world-class smile. Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how you would look after dental improvements, prior to any treatment. Imaging can be performed as part of your exam visit (at no additional charge). Would you like to see what you would look like with a new and improved smile? yes no If yes, please check the procedures below that you feel would improve your smile:

- | | | | |
|---|--|---|---|
| <input type="radio"/> lighten all front teeth showing | <input type="radio"/> rebuild fracture (s) | <input type="radio"/> straighten rotation | <input type="radio"/> eliminate dark/stained fillings |
| <input type="radio"/> lighten single tooth | <input type="radio"/> lengthen certain teeth | <input type="radio"/> straighten angulation | <input type="radio"/> reduce gum showing in smile |
| <input type="radio"/> close spaces between teeth | <input type="radio"/> shorten certain teeth | <input type="radio"/> eliminate crowding | <input type="radio"/> repair uneven edges |

your dental history

why have you come to the office today

previous / present dentist

city and state

date of last dental examination

were x-rays taken

was treatment recommended

was treatment completed

are you currently in pain

yes no

if so, where? _____

do you floss daily

yes no

do you brush daily

yes no

do you have bad breath

yes no

have you ever had gum treatment

yes no

do you breathe through your mouth while awake or asleep

yes no

please use this space for any additional comments

do your gums bleed

yes no

do you experience pain when cleaning teeth

yes no

have you ever had periodontal disease

yes no

do you have mobility in your teeth

yes no

do you clench or grind your teeth

yes no

If so, when: while awake while asleep

are your teeth sensitive to temperature or pressure

yes no

have you ever had pain in either jaw joint

yes no

are you aware of clicking or popping in either jaw joint

yes no

If so, when: opening mouth closing mouth

do you have chronic headaches, neck or shoulder pain

yes no

do you require antibiotics before dental treatment

yes no

are you aware of any sores or growths in your mouth

yes no

have you ever had complications following dental treatment

yes no

would you like to speak to the doctor privately about any issue yes no

your medical history

do you have a personal physician yes no

are you currently under the care of a physician yes no

physician's name

physician' phone number

under care of physician for (explain)

your current physical health is excellent good fair poor

date of last physician visit

do you smoke or use tobacco in any form yes no (describe)

are you taking any prescription/over the counter drugs (list all)

are you taking birth control pills yes no

are you pregnant yes no week #

are you nursing yes no

have you ever had any of the following diseases or medical problems:

abnormal bleeding yes no

aids yes no

alcohol / drug abuse yes no

anemia yes no

arthritis yes no

artificial bones / joints / valves yes no

asthma yes no

blood transfusion yes no

cancer / chemotherapy yes no

inflammatory bowel disease yes no

congenital heart defect yes no

diabetes yes no

difficulty breathing yes no

eating disorder yes no

emphysema yes no

epilepsy yes no

fainting spells yes no

frequent headaches yes no

glaucoma yes no

hay fever yes no

head or neck injury yes no

heart attack / surgery yes no

heart murmur yes no

hemophilia yes no

hepatitis yes no

herpes / fever blisters yes no

high blood pressure yes no

HIV yes no

hospitalized for any reason yes no

kidney problems yes no

liver disease yes no

low blood pressure yes no

mitral valve prolapse yes no

pacemaker yes no

psychiatric problems yes no

radiation treatment yes no

rheumatic / scarlet fever yes no

seizures / convulsions yes no

shingles yes no

sickle cell disease / traits yes no

sinus problems yes no

stroke yes no

thyroid problems yes no

tuberculosis yes no

ulcers yes no

venereal disease yes no

are you allergic to any of the following:

aspirin yes no

codeine yes no

novocaine or other dental anesthetics yes no

erythromycin yes no

jewelry / metals yes no

latex yes no

penicillin yes no

tetracycline yes no

other (describe) yes no
