Welcome to Art of Smile

Please take a few moments to fill out this necessary information that will enable us to better serve you. Our staff will be happy to assist you with any questions you may have.

PATIENT'S INFORMATION

Patient's Name: _____ Age: ____ Birth Date: _____ Sex: M/F ____

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

Patient lives with: _____ Home Number: _____

Preferred Name: _____ Work Number: _____

E-mail: _____ Interests/Hobbies: _____

MEDICAL HISTORY

Physician: _____ Last visit: _____ Phone: _____

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

Are you under a physician's care presently? Y/N What condition? _____

Date Updated: | | | | | |

IS THERE ANY FAMILY HISTORY OF: (PLEASE CIRCLE)

Y/N	Heart Disease	Y/N	Kidney Disease	Y/N	Nasal Blockage	Y/N	Emotional Problems
Y/N	Rheumatic Fever	Y/N	Diabetes	Y/N	Drug/Alcohol Use	Y/N	Psychiatric Therapy
Y/N	Heart Murmur	Y/N	Seizures	Y/N	Hepatitis/Jaundice	Y/N	Digestive Disorder
Y/N	High Blood Pressure	Y/N	Asthma	Y/N	Tuberculosis	Y/N	Hospitalization/Surg.
Y/N	AIDS/HIV+	Y/N	Arthritis	Y/N	Thyroid Disease	Y/N	Blood/Bleeding Disorder
Y/N	Frequent Colds	Y/N	Birth Defect	Y/N	Major Illness	Y/N	Unusual Childhood Disease

If you answered YES to any of the above, please explain. _____

Are you taking any medications? Y/N What? _____

Do you have any food/drug allergies? Y/N What? (*i e.penicillin, sulfa, latex, food, metals*)_____

Are you taking any medication for osteoporosis? Y/N _____

WOMEN: Are you pregnant? Y/N _____

GENERAL INFO

Does the patient play a musical instrument? Y/N Which? _____
Does any relative have a similar bite? Y/N Who? _____
Other relatives being treated here: _____

ORAL HEALTH HISTORY

Dentist: _____ Last visit: _____ Phone: _____

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

Why are you seeking treatment? _____ Referred by: _____

Do you consider treatment in this case to be mainly for: Health Cosmetics Psychological Other

_____

What would you like treatment to accomplish? _____

Would you like improvement in facial appearance? Y/N How? _____

IS THERE ANY HISTORY OF: (PLEASE CIRCLE)

Y/N	Clicking of jaw/joints (TMJ)	Y/N	Tongue Thrusting/habit	Y/N	Prior Orthodontic Treatment
Y/N	Pain in Jaw Joints (ears)	Y/N	Grinding teeth (Day/Night)	Y/N	Extra teeth
Y/N	Injuries to the teeth	Y/N	Pen, lip or nail biting	Y/N	Extraction of teeth
Y/N	Injuries to the face	Y/N	Thumb /finger sucking	Y/N	Missing teeth
Y/N	Difficulty Chewing	Y/N	Chewing gum	Y/N	Speech problem
Y/N	Fever blisters/Ulcers	Y/N	Mouth breathing	Y/N	Dry mouth

If you answered YES to any of above, please explain WHAT happened and WHEN? _____

_____

Please list any other information which you feel may be of value to the treatment. _____

_____

FINANCIAL

Insurance Subscriber: _____ Birth Date: _____
Employer: _____ SS# _____ Work Phone: _____
Employer Address: _____ City: _____ State: ___ Zip: _____
Insurance Company: _____ ID# _____ Group # _____
Orthodontic Coverage: Y/N _____ What Percentage? _____ % Max. Benefit? $ _____
Patient Portion? $ _____

To the best of my knowledge, all the preceding answers are true and correct. I hereby give permission to Dr. Amy James and her clinical team to take necessary x-rays, photos or study models to enable complete diagnosis as well as use of these records for educational purposes.

Patient Signature _____ Today's Date _____