THOROUGHDENT SMILES
FAMILY AND EMERGENCY DENTISTRY

Patient Information

Patient Name: _____ Today's Date: _____

Sex: __M __F Birth Date:_____ Age:_____ SSN:_____

Occupation:_____ check one : __ Single __ Married

Home Address:_____ City:_____ State: ____ Zip: ____

Email:_____

Home Phone #:_____ Cell:_____

Your Employer:_____

If patient is underage: Mother's DOB:_____ Father's DOB:_____

Emergency Information

Name:_____ Address:_____
Phone#:_____

How did you hear about us? __ Mail __ Georgetown Theater __ Town Money Saver __ Social Media __Google __ Yelp __ Personal Referral: name of referring you to us:_____

Person Responsible for Account:_____ SSN:_____

Email Address:_____ Home #:_____

Cell:_____ Employer:_____

Dental Insurance Information (Primary Carrier) if you have other dental insurance coverage please fill out second coverage insurance.

Insured's Name: _____ SSN:_____DOB:_____ Insured's Employer:_____ Insured's Company:_____

Insurance Company Address: _____

Phone #:_____ Group #:_____ Local #:_____

Insured's Name: _____ SSN:_____DOB:_____ Insured's Employer:_____ Insured's Company:_____

Insurance Company Address: _____

Phone #:_____ Group #:_____ Local #:_____

THOROUGHDENT SMILES
FAMILY AND EMERGENCY DENTISTRY

Patient Name_____

Dental History
□ Pain in mouth:□Upper □Lower/ □right□ Left
□ Sensitivity (hot, cold, sweets, pressure)
□ Discomfort when chewing
□ Headaches, ear aches, neck pain
□ Jaw joint pain
□ Teeth or fillings breaking
□ Repair chipped teeth
□ Grinding or clenching teeth
□ Bleeding, swollen or irritated gums
□ Loose, chipped or shifting your mouth
□ Bad breath or bad taste in your mouth

*What is the reason for visit today?

_____

*When was your last dental visit?

_____

*Do you have or have you ever had any of the following?

□ Braces
□ Periodontal (gum) treatments
□ CPAP machine
□ Dentures
□ Partial Dentures

*Are you interested in :
□ Close spaces
□ Botox/Filler
□ Replace old crowns that don't match other teeth
□ Whitening
□ Straighten
□ Replace silver fillings with tooth colored fillings
□ Replace missing teeth
□ Sedation dentistry: □ Nitrous□ IV

*Name of previous dentist

_____

Medical History
□ AIDS/HIV positive
□ Anemia
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Blood Thinner
□ Cancer
□ Chemotherapy Dates
□ Diabetes Type 1 Type 2
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Heart Murmur/Mitro Valve Prolapse
□ Hepatitis A B C
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Nervousness/Depression
□ Pacemaker
□ Pregnant (currently) due date_____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatism
□ Sinus Problems
□ Stent
□ Stomach Problems
□ Stroke
□ Thyroid Disease
□ Tobacco User (currently)
□ Tuberculosis
□ Tumors
□ Ulcers
□ Venereal Disease
□Other_____
*Medication list:

_____
_____
_____
_____
_____
_____
_____

*Do you have any allergies?
□Yes □ No
□Penicillin
□ clindamycin
□Codeine
□Sulfa Drugs
□Latex
□Costume Jewelry
IF other list:

_____
_____

*Are you taking any osteoporosis medications?
□Yes □ No
If yes list medications:

_____
_____

*Family Doctor:

_____
*Family Doctor Phone Number:

_____

Patient/Parent Signature_____ Date_____