SCHUMAN CENTER
DENTAL AESTHETICS

PATIENT NAME _____

Address_____ City _____ State _____ Zip _____

Birth date _____ Soc Sec # _____ Dental Insurance? ___Y ___N

Cell Phone_____ e.mail _____

Employer _____ Employer Phone:_____

Present position _____ How long held _____

Spouse/Guardian _____ Birthdate_____ Soc Sec # _____

Spouse/Guardian Employer_____ Cell Phone_____ Work phone _____

Present position _____ How long held _____

I heard about this dental office from: _____Internet _____Other ____Location

____Work/Friend - Whom may we thank for referring you to our office? _____

DENTAL HISTORY:

Have you ever had or experienced any of the following? (Indicate YES with a checkmark)

_____Tender teeth when chewing
_____Bad breath and/or unpleasant taste
_____Pain in or near your ears; popping or clicking
_____Sensitivity to hot, cold or sweets
_____Bleeding gums; spontaneously or upon brushing
_____ Discolored teeth
_____ Sore areas in the mouth
_____ Spaces between your teeth
_____ Treated by a periodontist
_____ Treated by an orthodontist

ARE YOU INTERESTED IN:

_____Personal instruction in the care of your mouth _____Teeth whitening _____Cosmetic makeover

MEDICAL HISTORY (confidential, repeated as needed):

_____ Any heart problems
_____ Hepatitis
_____ Prosthetic valves/joint
_____ High or low blood pressure
_____ Cancer/Malignancies
_____ Radiation treatment
_____ HIV/Positive
_____ Herpes Simplex
_____ Sinus problems
_____ Psychiatric care
_____ Circulatory problem
_____ Sleep apnea and/or snoring issues
_____Asthma

Have you had any other serious illness?_____ Explain _____

Do you have any medicine / DRUG or LATEX allergies? _____ Explain _____

Have you ever had any difficulty with anesthetics?_____ Explain _____

Please list medications currently taking: _____

Do you wish to discuss with the doctor any problem not listed?_____

AUTHORIZATION: I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information that appears on these dental and medical histories is correct to the best of my knowledge. **I acknowledge responsibility for fees associated with any legal aspects concerning collection of my account.**

_____ _____

Patient/Guardian (if minor) signature Date