Sparkling Smiles Fayetteville
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SPARKLINGSMILESFAYETTEVILLE.COM

WELCOME!

*Taking care of **your** individual needs based on the condition of **your** mouth allows us to provide you with the best care possible. Please complete this form and if you have any questions or concerns, please do not hesitate to ask for assistance.*
(Please print in ink)

Date _____

Patient Information

Full Legal Name _____ Preferred Name _____
First Middle Last
Address _____ City_____ State____ Zip_____
Home #_____ Work #_____ Cell #_____
Do you prefer to receive calls at: Home _____ Work _____ Cell _____
Date of Birth _____ Social Security #_____ Marital Status _____
Email Address _____
Employer _____ Occupation_____
Spouse or Parent's Name _____ Phone # _____
Special Hobbies or Interests _____

In case of emergency, is there someone in the local area that we can call for you?

Name _____ Phone #_____
Relationship _____

The highest compliment our patients can give us is the referral of their friends and family!

Whom may we thank for referring you to our office? _____

Insurance Information

Payment in full is appreciated at the time of service and as a courtesy we will file your insurance for you and assign benefits payable directly to you.

Full Legal Name of Insured _____ Relationship _____
Date of Birth _____ Social Security # _____
Employer _____ Insurance Carrier _____
Claims Address _____ City _____ State _____ Zip _____
ID # _____ Group #_____

Your Dental History

Reason for today's visit _____
Date of last exam _____ Date of last dental X-rays _____
How often do you brush? _____ How often do you floss? _____

Please circle any of the following concerns regarding your teeth:

Bad breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or jaw popping	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sores or growths in your mouth	Sensitivity to cold

Medical History

Name of Physician _____ Date of last health exam: _____
What was this exam for? _____
Have you been hospitalized in the last 5 years? (Please Circle) No ___ Yes ___
If yes, please give reason: _____
Are you currently under any routine care by a healthcare provider? No Yes

If yes, nature of care: _____

Please list all of the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

*For the following questions, **please circle yes or no**. All of your answers are for our records only and will be kept strictly confidential. Please note that during your initial visit you may be asked some questions about your response. Our team may also ask additional questions concerning your health.*

Have you ever had, or been treated for any of the following diseases or medical conditions?

Anemia or Blood Disorder?	No	Yes	High Blood Pressure?	No	Yes
Angina?	No	Yes	High Cholesterol?	No	Yes
Arthritis?	No	Yes	Jaw Pain?	No	Yes
Autoimmune Disease?	No	Yes	Joint Replacement?	No	Yes
Asthma?	No	Yes	When was the joint placed? _____ _____		
Cancer or Tumor?	No	Yes	Kidney Disease?	No	Yes
Cortisone Treatments?	No	Yes	Liver Disease?	No	Yes
Diabetes?	No	Yes	Mitral Valve Prolapse?	No	Yes
Emphysema or other			Nervous Disorders?	No	Yes
Respiratory/Lung Illness?	No	Yes	Pacemaker?	No	Yes
Epilepsy?	No	Yes	Previous Biopsies?	No	Yes
Fainting or Dizzy Spells?	No	Yes	Psychiatric Care?	No	Yes
Glaucoma/Macular Degeneration?	No	Yes	Thyroid?	No	Yes
Parkinson's Disease?	No	Yes	Radiation or Chemotherapy?	No	Yes
Bacterial Endocarditis?	No	Yes	Recurrent Illnesses?	No	Yes
Headaches?	No	Yes	Please Explain: _____		
Heart Valve (artificial) or			Skin Rash?	No	Yes
Heart Transplant	No	Yes	Sinusitis or Allergy Problems?	No	Yes
Heart Disease (congenital)	No	Yes	Slow-Healing Mouth Sores?	No	Yes
Heart Attack, Heart Stent,			Stroke/T.I.A.?	No	Yes
Heart Surgery?	No	Yes	Swelling of Feet or Ankles?	No	Yes
Date of procedure? _____			Unintentional Weight Loss/Gain?	No	Yes
Heart Murmur	No	Yes	Ulcers or Reflux?	No	Yes
Hepatitis, any form	No	Yes	Venereal Disease?	No	Yes
H.I.V. Infection/AIDS/or ARC	No	Yes			

What is your normal blood pressure? S_____/ D_____ Today: _____ /_____

Any other conditions not listed? No Yes
Please explain: _____
_____

Drug Allergies:

Are you allergic or ever had a reaction to any of the following? (please circle each drug that applies)

Local Anesthetics	No	Yes
Penicillin or other antibiotics	No	Yes
Aspirin, Ibuprofen or Tylenol	No	Yes
Codeine, Valium or other sedatives	No	Yes
Latex or Metals	No	Yes

Other (please specify) _____

Have you ever been treated with Bisphosphonate Drugs? **No** **Yes**

Do you consume grapefruits, grapefruit juice or grapefruit extracts? **No** **Yes**

Please list any medications you are currently taking and dosages:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Women Only:

Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Tobacco, Alcohol and Drugs:

Do you use tobacco? No Yes

If yes, circle type *Smoke* *Vape* *Chew* _____

Do you consume Alcohol? No Yes

If yes, approximately how many alcoholic beverages per week? _____

Do you use mood altering drugs other than medications previously listed? _____

Weight and Diet Considerations

Current Weight _____lbs. Number of meals eaten per day _____

Dietary Restrictions? _____ Food Allergies? _____

Sugar in your diet (circle one) *none* *slight* *moderate* *high*

Have you ever been told by your physician that you need to take any antibiotic before dental treatment? Yes _____ No _____

Have You Had Any Plastic Surgery? i.e. Botox, Collagen, etc. _____

How would you rate your level of dental anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

If you could wave a magic wand, and change anything about the appearance of your smile, what would it be?

_____
_____
_____

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____
_____
_____

Cancellation Policy

*In the event that you are unable to make your scheduled appointment without giving a **72 hour** notice, we reserve the right to charge a fee of **$100.00** for **each broken** appointment.*

Authorization

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I certify that I have read and understand the above information and have answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I understand that I am responsible for notifying Dr. Dave C. Lee of any change in my health or medications. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payer and/or health care provider or agency.

I agree to be responsible for payment of all services rendered to me on my behalf or my dependents. I also give permission for Dr. Lee or his staff to use any photos taken in his office for lecturing or educational purposes.

Signature _____ Date_____