SMILE ONE DENTAL
Jessica Lien, DDS
(972) 372-9170
617 K Ave. #300 Plano, TX 75074

PATIENT INFORMATION

Patient name:_____ Preferred name:_____ Birthdate:_____ Sex: F / M

Driver license #:_____State:_____ SS #:_____ Status: □Single □Married □Other

Do you consent to having a photo of you/patient in your chart for identification? □YES □NO

Best phone # to reach you:_____ E-mail:_____

Preferred Method of Contact: □Phone □E-mail □Text

Home address:_____ City:_____ State:_____ Zip:_____

Spouse's name & number:_____

Emergency contact & number (if other than spouse):_____

Employer/Occupation:_____ Work phone:_____

Primary dental insurance:_____Policy holder:_____ Birthdate:_____ SS #:_____

How did you hear about us?_____

We dedicate our valuable time caring for you, so if possible, please give us 24 hours notice if you have to cancel or reschedule your appointment. When a patient does not give us enough notice, it does prevent other patients from being seen for that available time. Missed/no show appointments and cancellations without 24 hour notice will incur a $50 fee.

DENTAL HEALTH HISTORY

Name of previous dentist:_____ Date of last visit to dentist:_____

Reason for today's visit:_____

Are you apprehensive about dental treatment?——□YES □NO
Have you had any problems with previous dental treatment?——□YES □NO
Do you gag easily?——□YES □NO
Do you wear dentures?——□YES □NO
Does food catch between your teeth?——□YES □NO
Do you have difficulty chewing?——□YES □NO
Do your gums bleed during brushing/flossing?——□YES □NO
Are your teeth sensitive?——□YES □NO
Are you satisfied with the appearance of your teeth?——□YES □NO
Does your jaw pop, click, or bother you?——□YES □NO
Do you clench or grind your teeth?——□YES □NO
Do you have any jaw symptoms or headaches in the mornings?——□YES □NO
Do you have any discomfort that is affecting daily routine?——□YES □NO
Do you take medications for pain or discomfort?——□YES □NO
Have you ever had any trauma to the jaw?——□YES □NO

MEDICAL HEALTH HISTORY

Name of your medical doctor:_____ Date of last visit to medical doctor:_____

Do you have, or have you had, any of the following? CHECK ANY THAT APPLY.

Heart problems ——— □
- Chest pain/angina ——— □
- Shortness of breath ——— □
- High blood pressure ——— □
- Low blood pressure ——— □
- Heart murmur ——— □
- Heart valve problem ——— □
- Rheumatic fever ——— □
- Pacemaker ——— □
- Artificial heart valve ——— □

Diabetes ——— □

Asthma ——— □

Respiratory disease (COPD, other) ——— □

Blood problems ——— □
- Easy bruising ——— □
- Abnormal bleeding ——— □
- Anemia ——— □
- Ever had blood transfusion? ——— □

Allergies ——— □
- Hay fever ——— □
- Sinus problems ——— □
- Skin rashes ——— □
- Seasonal ——— □

Intestinal problems ——— □

Artificial joints ——— □

Ulcers ——— □

Kidney or bladder problems ——— □

Seizure, fainting spells, epilepsy ——— □

Arthritis ——— □

Strokes ——— □

Thyroid problems ——— □

Persistent cough or swollen glands ——— □

Tuberculosis ——— □

Liver disease ——— □
- Hepatitis ——— □
- Jaundice ——— □

Herpes ——— □

STD ——— □

HIV-positive/AIDS ——— □

Glaucoma ——— □

History of head injury ——— □

Neurological disorders ——— □

Drink alcohol? ——— □
- If so, how much?_____

History of alcohol or drug abuse? ——— □

Use tobacco? ——— □
- If so, how much?_____

History of cancer? ——— □
- If so, what type and year of diagnoses?

_____

Chemotherapy/radiation? ——— □

Women:
- Pregnant? ——— □
- Taking contraceptives? ——— □

Please list any diseases, conditions, or problems not previously listed?

_____

_____

Please list any allergies or adverse reactions.

_____

Are you currently taking any medications? If yes, please list all the medications you are taking.

_____

_____

_____ _____ _____

Patient name/guardian Signature Date