WELCOME TO FLATIRONS FAMILY DENTAL & ORTHODONTICS

To aid us in providing diagnosis and treatment for your dental needs, please completely fill out this confidential questionnaire.

Patient Name: _____Date: _____
Date of Birth: _____Age: _____Sex: _____Marital Status: _____
E-Mail Address: _____Social Security #: _____
Mailing Address: _____Home Phone #:_____
_____Cell Phone #:_____
City State Zip Code Work Phone #:_____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Date of Birth: _____
Relationship to patient: _____ Employer:_____
Dental Insurance Carrier: _____
Social Security # or Identification #:_____ Group #:_____

Please, whom may we thank for referring you to our office: _____

HEALTH HISTORY

Name of family physician: _____ Location: _____

How is your general health? Excellent Good Fair Poor

Do you have, or have you ever had, any of the following? Please circle.

Heart Disease	Diabetes	Tumor History	Liver Disease
AIDS	Stroke	Ulcers	Allergies
Epilepsy	Asthma	Blood Disorder	Tuberculosis
Hepatitis	Sinus Trouble	Fainting	Rheumatic Fever
Anemia	Arthritis	Heart Murmur	Emphysema
Thyroid Disease	Kidney Disease	Radiation	Psychiatric Treatment
High Blood Pressure	Venereal Disease	Sleep Apnea	Mitral Valve Prolapse

Have you ever been hospitalized and/ or had surgery within the last five years? YES NO
If yes please explain: _____
Are you under the care of any physician now? YES NO
If yes, please explain: _____
Are you taking any medication, drugs or pills? YES NO
If yes, please list: _____
Are you allergic or sensitive to penicillin or any other medication? YES NO
If yes, please list: _____
Do you have any disease, condition or problem not listed above? YES NO
If yes, please list: _____
Do you smoke? YES NO
Women: Are you pregnant? YES NO

If yes, what is your due date? _____

DENTAL HISTORY

Are you currently in discomfort requiring our immediate attention?	YES	NO
If yes, please explain: _____		
Have you had regular dental checkups?	YES	NO
When was your last visit? _____ What was done then? _____		
Do your gums bleed when brushing or flossing?	YES	NO
Have you lost multiple teeth?	YES	NO
If yes, please explain why? _____		
Are you apprehensive about receiving dental treatment?	YES	NO
Have there been any complications during previous dental treatment?	YES	NO
If yes, please explain: _____		
Do you have frequent headaches?	YES	NO
Do you clench or grind your teeth during wake or sleep?	YES	NO
Do your jaws feel tired or sore when you're awake?	YES	NO
Do your jaw joints grind, pop, click or lock?	YES	NO
Have you ever been diagnosed with sleep apnea?	YES	NO
Do you feel tired or fatigued throughout the day?	YES	NO
Do you snore?	YES	NO
Have you ever had Botox treatments in the past?	YES	NO
Have you ever considered having Botox treatments?	YES	NO
Is there anything you would change about your smile?	YES	NO
Please explain: _____		

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergencies. These procedures may include radiographs, models and intraoral examination. In case of a dental emergency, I consent to treatment as deemed as necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent to the use of local anesthetics and relaxants for completing the necessary dental treatment.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE POLICY

_____

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE DATE