smileboston™
cosmetic & implant dentistry

Thank you for selecting ***Dr. Steven D. Spitz*** and ***Smileboston Cosmetic and Implant Dentistry*** to work with you in caring for your oral health. We strive to provide you with exceptional service every time you visit us. The following information is necessary, and for our records only. All information is kept strictly confidential. If you have any questions or need assistance in completing this information, please ask.

PERSONAL INFORMATION: Today's Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Email _____ This email is my **Home** ❑ **Work** ❑

Social Security Number _____ Birth Date _____

Home phone _____ Cell Phone _____

Please check one: Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑

Spouse's Name _____ Cell Phone _____

Confirm my appointments at: **Home** ❑ **Work** ❑ **Cell** ❑ **Email** ❑

When was your last dental visit? _____ Doctor ❑ Hygiene ❑ Both ❑

EMPLOYER:
Company _____Work Phone _____

Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION:
Name _____Relationship_____

Home Phone _____ Work Phone _____

NEAREST RELATIVE NOT *LIVING WITH YOU:*

Name _____Relationship_____

Home Phone _____ Work Phone _____

PLEASE CONTINUE ON THE NEXT PAGE ➔ ➔ ➔ ➔

MEDICAL HISTORY:

Physician's Name _____ Phone number _____

Approximate date of last exam _____ Are you under medical care now? Yes ❑ No ❑

Have you been hospitalized for surgical care or serious illness within the last five (5) years? Yes ❑ No ❑

Are you taking any medication(s) including vitamins or non-prescription medicine? Yes ❑ No ❑

If yes, please be specific. _____

Do you use tobacco?	Yes ❑	No ❑
Do you use controlled substances?	Yes ❑	No ❑
Do you wear contact lenses on a regular basis?	Yes ❑	No ❑
Do you use extra pillows to sleep?	Yes ❑	No ❑

WOMEN ONLY:

Are you taking oral contraceptives?	Yes ❑	No ❑
Are you pregnant could you possibly be pregnant?	Yes ❑	No ❑
Are you nursing?	Yes ❑	No ❑
Have you entered menopause?	Yes ❑	No ❑
Do you take estrogen?	Yes ❑	No ❑

If so, what type? _____

Are you aware of having an adverse allergic reaction to the following?

Local Anesthetics	Yes ❑	No ❑	Sedatives	Yes ❑	No ❑
Iodine	Yes ❑	No ❑	Sulfa drugs	Yes ❑	No ❑
Latex rubber	Yes ❑	No ❑	Aspirin	Yes ❑	No ❑
Barbiturates	Yes ❑	No ❑	Antibiotics (Penicillin, etc.)	Yes ❑	No ❑
Metals (nickel, mercury, etc.)	Yes ❑	No ❑			

Other, please explain in detail _____

Do you have or have you had any of the following:

High Blood Pressure	Yes ❑	No ❑	Diabetes	Yes ❑	No ❑
Low Blood Pressure	Yes ❑	No ❑	Stroke	Yes ❑	No ❑
Heart Attack/ Heart Disease	Yes ❑	No ❑	Arthritis	Yes ❑	No ❑
Rheumatic Fever	Yes ❑	No ❑	Angina	Yes ❑	No ❑
Swollen Ankles	Yes ❑	No ❑	Cancer	Yes ❑	No ❑
Fainting/Seizures	Yes ❑	No ❑	Leukemia	Yes ❑	No ❑
Asthma/Chronic Bronchitis	Yes ❑	No ❑	Anemia	Yes ❑	No ❑
Epilepsy/Convulsions	Yes ❑	No ❑	Tuberculosis	Yes ❑	No ❑
Kidney Disease	Yes ❑	No ❑	Glaucoma	Yes ❑	No ❑
AIDS or HIV infection	Yes ❑	No ❑	Emphysema	Yes ❑	No ❑
Thyroid Problems	Yes ❑	No ❑	Liver Disease	Yes ❑	No ❑
Bone Infection/Disorder	Yes ❑	No ❑	Weight Loss	Yes ❑	No ❑
Chest Pains/Easily Winded	Yes ❑	No ❑	Emotional Disturbances	Yes ❑	No ❑
Sinusitis/Sinus Issues	Yes ❑	No ❑	Hay Fever/Allergies	Yes ❑	No ❑
Radiation Therapy	Yes ❑	No ❑	Osteoporosis	Yes ❑	No ❑
Frequently Tired	Yes ❑	No ❑	Respiratory Trouble	Yes ❑	No ❑
Joint Replacement or Implant	Yes ❑	No ❑	Hepatitis/Jaundice	Yes ❑	No ❑
Sexually Transmitted Diseases	Yes ❑	No ❑	Stomach Ulcers	Yes ❑	No ❑

PLEASE CONTINUE ON THE NEXT PAGE ➔ ➔ ➔ ➔

DENTAL HISTORY:

Previous Dentist's Name _____ Phone number_____

Approximate date of last exam _____ Are you under dental care elsewhere? Yes ❑ No ❑

Do you clench or grind your teeth while awake or asleep?		Yes ❑	No ❑
Do your gums bleed while brushing or flossing?		Yes ❑	No ❑
Have your parents experienced gum disease or tooth loss?		Yes ❑	No ❑
Are you satisfied with the appearance of your teeth?		Yes ❑	No ❑
Are you sensitive to:	Sweet or sour liquids or foods?	Yes ❑	No ❑
	Hot or cold liquids or foods?	Yes ❑	No ❑
	Biting or chewing?	Yes ❑	No ❑
Do you:	Bite your cheeks or lips regularly?	Yes ❑	No ❑
	Hold foreign objects with your teeth?	Yes ❑	No ❑
	Feel pain in any of your teeth?	Yes ❑	No ❑

Have you noticed:

Clicking in your jaw	Yes ❑	No ❑
Pain (joint, ear, side of face)	Yes ❑	No ❑
Pain when opening/closing	Yes ❑	No ❑
Headaches	Yes ❑	No ❑
Neck or shoulder aches	Yes ❑	No ❑
Difficulty chewing	Yes ❑	No ❑
Mouth odors or bad tastes	Yes ❑	No ❑
Sores or lumps in/near your mouth	Yes ❑	No ❑
Tired jaws in the morning	Yes ❑	No ❑

Have you had any of the following:

Orthodontic Treatment	Yes ❑	No ❑
Periodontal Treatment	Yes ❑	No ❑
Oral Surgery	Yes ❑	No ❑
A bite plate or mouthguard	Yes ❑	No ❑
Your teeth ground	Yes ❑	No ❑
Your bite adjusted	Yes ❑	No ❑

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately, and will not hold Dr. Spitz or any member of his team responsible for any errors or omissions that I may have made in the completion of this form. I understand that I can request assistance at any time to complete this form.

I authorize and consent to the use of certain photographs/x-rays of me taken by Steven D. Spitz, DMD and I hereby grant Dr. Spitz permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or to promote this office. These photographs/x-rays may be in the form of prints, slides, or film for use in connections with articles, lectures, or television broadcasts dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of treatment to third party payers and/or health practitioners. I understand and acknowledge that I am financially responsible for the services provided for my dependents and myself, regardless of insurance coverage.

_____

Signature of patient or guardian Today's date

_____

Print name of patient or guardian Relationship to patient, if guardian

DENTAL INSURANCE INFORMATION:

Insured's Name _____ Birth Date _____

Social Security #_____Relationship to Patient _____

Insured's Employer _____

Insurance Company _____

Address _____ City _____ State_____ Zip _____

Group/Policy Number _____

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How did you hear about ***Dr. Spitz/Smileboston Cosmetic and Implant Dentistry***?
Please be as specific as possible. Doctor/Patient referrals, Radio, Insurance, Dr. Spitz's Article(s), Magazine, TV News Report, (If the Internet, what keywords were important? What site did you start with?)

_____

_____

What Radio Station(s) do you prefer during treatment? _____

What Magazine(s)/Newspapers would you like to see in our reception area?

_____

Which of the following are factors for you as it relates to your dental treatment?
Fear of Treatment ❑ Fee for Treatment ❑ Time/Scheduling ❑
Other *(please explain)*

_____

Would you like an application for financing? Yes ❑ No ❑

Is there anything additional that we should know that would allow us to make your experience at ***Smileboston Cosmetic and Implant Dentistry*** exceptional?

_____

_____

*At **Smileboston**, we depend on your feedback, both positive and constructive, to excel.*
We appreciate every comment. Thank you for your time and for experiencing our office.