Northern Smiles Dentistry & Orthodontics
7501 North 16th Street, Suite 100, Phoenix, AZ 85020

Patient Information

Patient Name: _____ SSN#: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-Mail: _____ Employer: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Whom may we thank for referring you? _____

Spouse or Responsible Party Information

Name: _____ SSN#: _____ Birth date: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____ City: _____ State: _____ Zip: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Do you need to Premedicate for dental appointments? ☐ Yes ☐ No If so, why? _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
  - ☐ Radiation Therapy
  - ☐ Chemotherapy
  - ***Last treatment*** _____
- ☐ Chemical Dependency
- ☐ Cortisone Treatment
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema or COPD
- ☐ Epilepsy or Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Problems
  - ***Describe*** _____
- ☐ Hemophilia/Bleeding
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Osteoporosis
  - ☐ taking bisphosphates
- ☐ Pacemaker
- ☐ Pregnancy
  - Due Date _____
- ☐ Psychiatric Care
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Sinus Problems
- ☐ Stomach Problems/GERD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:
- ☐ _____
- ☐ _____
- ☐ _____

Please list all medications (prescription and OTC):

☐ None

_____

_____

_____

_____

_____

_____

Please list all allergies:

☐ None

_____

_____

_____

_____

_____

_____

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Are your teeth sensitive to hot, cold or sweets?_____

Do your gums bleed easily, feel tender or irritated?_____

Do you often have sores or fever blisters in your mouth?_____

Are there areas in your mouth where food sticks or gets caught?_____

Do your jaws often feel tired or sore?__ If yes, when do you notice this feeling?_____

Do you experience clicking popping noises when opening or closing your mouth, or when chewing?_____

Are you aware of grinding or clenching your teeth?_____

Are you satisfied with your past dentistry?_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

_____

Additional information you would like to share: _____

_____

Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Print Name:_____

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Dentist Signature:_____ Date_____