

WELCOME TO SOFTOUCH ~ DENTAL

Please fill out this form completely. In order to make proper diagnosis and help you to improve and to maintain your oral health, we need to gather as much information about you as possible. Thank You

ABOUT YOU

Today's Date: _____ Email Address: _____

Name: _____ I prefer to be called: _____
Last First M.I

Birth Date: ____/____/____ Age: _____ Social Security #: _____

I am: ___Single ___Married ___Divorced ___Widowed Driver's License #: _____

Home Address: _____
Street City State Zip

Home Phone #: _____ Cell #: _____ Work Phone #: _____

Preferred Appointment Times: _____

Preferred Appointment Dates: _____

Whom May We Thank For Referring You? _____

Other Family Members Seen By Us: _____

Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Spouse or Emergency Contact Information

His/Her Name: _____ Birth Date: ____/____/____ Relationship: _____

Home Phone # _____ Work Phone # _____ Ext # _____

Insurance Information / Responsible Party Information

Name (if other than patient's name) Relationship to Patient

Address City State Zip

Policy Holder's Date of Birth Social Security Number

Employer's Name Occupation How Long Have You Been There

Insurance Company Insurance's Phone # Group or Policy Number

DENTAL HISTORY

What is your main reason for visiting the Dentist Today? _____

Your current **dental health** is: _____ Good _____ Fair _____ Poor

Are your teeth currently in **Pain**? If Yes, **where** in your mouth do you have pain? _____

From a scale of **1-10**, How would you classify your pain? _____

What **type of pain** do you have? Is it a **Dull** pain? **Sharp** Pain or **Throbbing** pain? _____

Are your teeth sensitive to the following: _____ **Cold**, _____ **Sweet**, _____ **Chewing**?

Does the pain keep you up at night? _____

Are you under a lot of stress, if yes, please describe _____

Do you have any **loose teeth**? _____

Do you have **bleeding gums**? _____

Do you require **antibiotics** before dental treatment? _____

Have you ever had **gum treatment, deep cleaning** done, if Yes, when _____

Do you **brush** and **floss** daily? _____

Previous / Present Dentist: _____ Last Visit Date: _____

(Please Circle)

Why do you discontinue seeing your last dentist? _____

Have you ever had any **bad dental experience** in the past? If Yes, please describe: _____

If you could change one thing about your smile, what would it be? _____

Would you like to have **straighter** teeth using: _____ Braces _____ Invisalign

Would you like to have **whiter teeth** using: _____ In-Office Bleaching _____ Home Bleaching

Do you **snore**? If Yes, would you like to stop snoring? _____

Do you **clench** or **grind** your teeth? _____

Do you have: _____ **difficulty in chewing** _____ **opening/closing** _____ **pain in the jaw joint**

Would you like to have the following tests: (please check)

_____ Diabetes _____ Cholesterol _____ Oral Cancer Screening using **Vizilite**

Please place an "X" where **you think your level of trust in the dental care providers** in general.

POOR AVERAGE EXCELLENT
|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

Please place an "X" where **you would like to see your level of oral health** will be five or ten years from now.

POOR AVERAGE EXCELLENT
|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

MEDICAL HISTORY

Your current **physical health** is: _____ Good _____ Fair _____ Poor

Do you have a **personal Physician**? If Yes, **Physician Name**: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a Physician? If Yes, please explain: _____

Do you **smoke**? If yes, **how long** and **how many pack** per day? _____

Do you **chew tobacco**? If yes, **how long** and **how many packs** per day? _____

For WOMEN:

Are you taking Birth Control Pills? If yes, how long? _____

Are you pregnant? If yes, how long have you been pregnant? _____

Are you nursing? If yes, how long? _____

Have you ever experienced the following?

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidneys Problems	<input type="checkbox"/> Steroid Therapy	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Multiple Myeloma
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dialysis Treatment	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> TMJ Syndrome	<input type="checkbox"/> Fever Blister	<input type="checkbox"/> Mitral Valve Prolapsed	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Paget's Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> HIV + / AIDS
<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Headaches
<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Epilepsy: Petite - Grand	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Lupus	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Joint Replacement*	<input type="checkbox"/> Steroid Therapy
<input type="checkbox"/> Colitis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Seizures	<input type="checkbox"/> Congenital Heart Defect*	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Shingles	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes	<input type="checkbox"/> Endocarditis*	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Heart Valve Transplant*	<input type="checkbox"/> Hepatitis A – B – C

Do you have any condition that is not listed above? If yes, please describe _____

Have you ever been **hospitalized**? If yes, **when** and for **what reason**? _____

Have you ever had a **stroke** or a **heart attack**, if yes, when? _____

Have you ever been diagnosis with cancer? If yes, when and what type of cancer? _____

Have you ever taken Biphosphonate, if yes, for how long? _____

Are you **currently** taking any **Prescription Drugs, Over-The-Counter Drugs, Vitamin, Herb**? If Yes, please list or attach a copy of the list. _____

Are you **ALLERGIC** to any medication, food, or any other products, if yes, what it is? _____

AUTHORIZATION

I hereby authorize doctor or staff to take x-rays, diagnostic models, photographs or any other diagnostic aids to make a thorough diagnosis of the patient's dental needs. I also authorized the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risk and that I can ask for a complete recital on any possible complication. I understand that I am responsible for payment of service rendered. I understand that payment is due at the time of service unless other arrangements have been made. I hereby give Dr. Jennifer Nguyen the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Signature of Patient, Parent or Guardian

Date

Relationship to Patient