Scott Bonin, DDS

Getting Acquainted

Patient's Name _____Birthdate_____

Residence_____ Phone_____

City/State/Zip_____

Occupation_____Employer_____SSN#_____

Bus. Phone_____Dental Insurance Name_____

E-mail address_____ **Website Address**_____

Former Dentist_____Last Visit_____

Address/Phone No._____

Personal Physician_____Phone_____

Spouse Name_____Birthdate/SSN#_____

Names/Ages of Children under 18_____

In case of emergency, contact (name/relationship to patient/phone number)

_____

Whom may we thank for referring you to this office?_____

If patient under 18, adult accompanying minor is responsible for payment:

Name (last, first, middle initial)_____

Relationship to Patient_____Phone_____

Address/City/Zip_____

Place of Employment_____SSN#_____

Business Address_____Bus. Phone_____

City/State/Zip_____

I am 18 or older and understand that I am financially responsible for all charges.

Signature:_____Date:_____

Scott Bonin, DDS

Name _____

Medical History

Yes No Check (Y/N) Nos. 1-26. Please complete "Smile Evaluation" section. **All information is confidential.**

___ ___ 1. Have you been hospitalized for a serious illness or surgical procedure? _____
___ ___ 2. Have you been under a physician's care? If yes, please explain:_____
___ ___ 3. Are you now taking any medication (drugs or pills)? List:_____
___ ___ 4. Do you smoke? Or use smokeless tobacco? ____Y ____N

5. Have you had any of the following?

___	___	Heart Disease	___	___	Psychiatric Treatment
___	___	Heart Attack	___	___	Fainting/Dizzy Spells
___	___	High Blood Pressure	___	___	Emphysema
___	___	Angina Pectoris	___	___	Asthma
___	___	Heart Surgery	___	___	Diabetes
___	___	Heart Pacemaker	___	___	Thyroid Disease
___	___	Artificial Heart Valve	___	___	Arthritis
___	___	Heart Defect or Murmur	___	___	Glaucoma
___	___	Artificial Joints	___	___	Liver Disease
___	___	Persistent Cough	___	___	Yellow Jaundice
___	___	Allergies or Hives	___	___	Epilepsy or Seizures
___	___	Abnormal Bleeding	___	___	Hep A (Infectious)
___	___	Ulcers	___	___	Hep B (Serum)
___	___	Kidney trouble	___	___	Hep C
___	___	Sinus trouble	___	___	HIV Positive
___	___	Cold Sores	___	___	AIDS
___	___	Fever Blisters	___	___	Venereal Disease
___	___	Hay Fever	___	___	Drug Addiction
___	___	Anemia	___	___	IV Drug Use
___	___	Blood Disease	___	___	Alcoholism
___	___	Blood Transfusion	___	___	Turberculosis
___	___	Nervousness or Anxiety	___	___	Radiation/Chemotherapy
___	___	FenPhen/Redux Diet Pill	___	___	Rheumatic Fever
___	___	Eating Disorders	___	___	Scarlet Fever

___ ___ 6. Do you have any disease, condition or problem not listed above that you think Dr. Bonin should know about?_____

Women: 7. Are you pregnant? ___Y___N; Nursing? ___Y ___N; Taking birth control pills? ___Y ___N

Medicament Inquiry

___ ___ 8. Are you allergic (or react adversely) to any of the following?

Aspirin	Local Anesthetic	Tetracycline
Codeine	Penicillin	Sulfa
Nitrous Oxide	Erythromycin	Latex or Rubber materials

___ ___ 9. Are you allergic to any other medication or substance? If yes, please list: _____

Signature_____ Date_____

Scott Bonin, DDS

Name_____

Dental and Periodontal History

Yes	No	
__	___	10. Are you having pain or discomfort at this time?
___	___	11. Do you feel very nervous about having dental treatment?
___	___	12. Have you ever had a bad experience in a dental office? Please describe_____
		_____
___	___	13. What did you like about your previous dental office?_____
		_____
___	___	14. Did you go to the dentist on a regular basis? Every _____months or _____year
___	___	15. Do your gums bleed when you brush or floss your teeth?
___	___	16. Do you have any loose teeth? Do you know why they're loose _____yes _____no
___	___	17. Does it appear to you that your gums are receding (pulling away from your teeth)?
___	___	18. Have you ever experienced an unusual odor coming from you mouth?
___	___	19. Do your gums appear red or puffy?
___	___	20. Are you experiencing sensitivity to hot or cold foods or beverages?
___	___	21. Do you have any missing teeth?
___	___	22. Do you wear a full or partial denture? ____ top ____ bottom
___	___	23. Do you ever experience pain in your jaw muscle?
___	___	24. Do you clench or grind your teeth?
___	___	25. Do you own an bite guard? Do you wear it ____daily___occasionally
----	-----	26. Do you see a chiropractor regularly?
__	___	27. Do you see a massage therapist on a regular basis?

Smile Evaluation

For most people, an appealing smile is an important part of the overall impression a person makes to the world. Although a vast number of adults understand the importance of a good smile, only half think their smile "makes the grade." Does YOUR smile say it all?

On a scale of 1 to 10, how would you rate your smile (10=spectacular, 1=not pleasing)?_____

If there were anything that you could change about your smile, what would that be?

_____

_____

How would you like your teeth and gums to look and feel for the rest of your life?

_____

_____

How do you feel about the color of your teeth? Please explain.

_____

_____

Authorization and Consent

I authorize and give consent to Dr. Bonin to perform any dental treatment we agreed to be necessary or advisable, including the use of local anesthesia or other medication. If patient is a minor, parent or guardian must sign.

Signature_____Date_____

(Parent or guardian if patient under 18 years)

Medical and Dental History Reviewed_____/_____/_____/_____