

# Welcome!

Thank you for choosing LifeSmile Dental Care. Please complete this form. If you have any questions we will be glad to help. (Please print)

## PATIENT INFORMATION

Date: \_\_\_\_\_ Name \_\_\_\_\_ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Other: \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_ DOB: \_\_\_\_\_ [ ] Male [ ] Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home #(\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work #(\_\_\_\_) \_\_\_\_\_ Cell #(\_\_\_\_) \_\_\_\_\_

SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_ @ \_\_\_\_\_

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Contact # (\_\_\_\_) \_\_\_\_\_ [ ] Cell [ ] Work

### **Responsible Party** (if different than patient)

Name \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact#(\_\_\_\_) \_\_\_\_\_ [ ] Cell [ ] Home

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# \_\_\_\_\_

Relationship: \_\_\_\_\_

### **About LifeSmile Dental Care:**

Since 1982, LifeSmile Dental Care has been providing exceptional dental care for patients in the St. Louis area. Based on a deep, personal belief in the importance of each patient's dental health, our office pledges to provide the best dental care in a compassionate and friendly environment.

*Our services include: general dentistry, cosmetic dentistry, Invisalign, implant restorations, same day crowns, teeth whitening and much more!*

## PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at: [ ] Home [ ] Cell [ ] Work

Whom may we thank for referring you: \_\_\_\_\_

How do you wish to be addressed by our staff: \_\_\_\_\_

## INSURANCE INFORMATION

### **MEDIAL INSURANCE:**

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

SSN# or ID# \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### **DENTAL INSURANCE:**

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

SSN# or ID# \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Contact# (\_\_\_\_) \_\_\_\_\_ Effect. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**DO YOU HAVE ADDITIONAL DENTAL INSURANCE?** [ ] Yes [ ] No *If yes, please complete the following:*

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

SSN# or ID# \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Contact# (\_\_\_\_) \_\_\_\_\_ Effect. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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8430 PERSHALL RD~ HAZELWOOD, MO~ 63042

(314) 521-5678

## MEDICAL HISTORY & CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

### ALLERGIES

Aspirin	Y	N
Barbiturates	Y	N
Codeine	Y	N
Erythromycin	Y	N
Jewelry	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Sedatives	Y	N
Sulpha	Y	N
Other	Y	N

List any other known Allergies:

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### CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain	Y	N
Congenital Heart Defect	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Heart Surgery	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N

### ENDOCRINE

Diabetes	Y	N
Thyroid Problems	Y	N

### EYES, EARS, NOSE & THROAT

Difficulty Swallowing	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillitis/Tonsillectomy	Y	N

### GASTROINTESTINAL

Acid Reflux	Y	N
Ulcers	Y	N

### GENERAL

Anemia	Y	N
Arthritis	Y	N
Cancer	Y	N
Colitis	Y	N
Fatigue/Tired	Y	N
Headaches (severe)	Y	N
Herpes/Fever Blisters	Y	N
HIV/AIDS	Y	N
Kidney Disease	Y	N
Knee/Hip Replacement	Y	N
Liver Problems	Y	N
Lupus	Y	N
Nursing	Y	N
Pregnant	Y	N
Recent Trauma/Injury	Y	N
Rheumatic/Scarlet Fever	Y	N
Radiation Treatment	Y	N
Shingles	Y	N
Venereal Disease	Y	N
Weight Change	Y	N

### HEMATOLOGICAL

Bleeding Problems	Y	N
Blood Transfusion	Y	N
Hepatitis	Y	N
Hemophilia	Y	N
Blood Thinners	Y	N

### ORAL/DENTAL

Bleeding Gums	Y	N
Dry Mouth	Y	N
Jaw Problems (TMJ)	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Swallowing	Y	N
Difficulty Chewing	Y	N
Ortho/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Teeth Grinding	Y	N
Tooth Pain	Y	N
Wisdom Teeth Extraction	Y	N
Do you take antibiotics	Y	N
before dental procedures?	Y	N

### MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Osteoporosis/Bisphosphonate Use	Y	N

### NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness/Fainting	Y	N
Epilepsy	Y	N
Memory Loss	Y	N
Multiple Sclerosis	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N

### PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorder	Y	N

### RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Emphysema	Y	N
Persistent Cough	Y	N
Tuberculosis	Y	N

### SLEEP

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
Has anyone told you that you snore?	Y	N

### SOCIAL HISTORY

Do you smoke?	Y	N
Do you use smokeless tobacco?	Y	N
Do you consume alcoholic beverage?	Y	N
_____ Drinks per day/week/month		
Do you use recreational drugs?	Y	N

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

What is the reason for your dental visit today? \_\_\_\_\_

Previous/Present Dentist Name \_\_\_\_\_ Office Location \_\_\_\_\_

Office #: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Are you happy with the way your smile looks? [ ] Yes [ ] No If not, what would you change? \_\_\_\_\_

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