NORTHLAKE DENTISTRY
STACY SCHMITT,DDS,PA

Please fill out this form as completely as you can. Providing incorrect information can be dangerous to your health and complicate treatment. If you have any questions, we would be glad to assist you!

Patient's Name _____ **Date** ____/____/____

Dental History

What brings you to our office today? _____
What is your immediate dental concern? _____ Are you in pain? □ No □ Yes
How often do you see a dentist? _____ How often do you brush your teeth? _____

Please check the box if you have had in the **past** or have in the **present** any of the following:

- □ Abscess in mouth
- □ Any food traps
- □ Bad breath
- □ Bad Taste
- □ Bite nails/objects
- □ Bleeding gums
- □ Blisters on lip/mouth
- □ Braces (orthodontics)
- □ Chew on one side
- □ Chew tobacco
- □ Clench/grind teeth
- □ Clicking/popping in jaw
- □ Cold sores
- □ Dental anxiety/fear
- □ Difficulty chewing
- □ Difficulty opening mouth
- □ Difficulty swallowing
- □ Drink alcohol
- □ Dry mouth
- □ Extractions of teeth
- □ Gag easily
- □ Infection in gums
- □ Loose teeth
- □ Missing teeth
- □ Pain around ears
- □ Pain in jaw joint
- □ Periodontal treatment
- □ Root canal treatment
- □ Sensitive gums
- □ Sensitive to cold/hot
- □ Sensitive to sweets
- □ Smoke tobacco
- □ Stained teeth
- □ Swelling
- □ Wear night/occlusal guard
- □ Wear replacement teeth

Please provide additional information and an explanation for those items checked above:
_____
_____
_____
_____

Please rate the appearance of your smile: (I hate my smile.) 1 2 3 4 5 6 7 8 9 10 (I love my smile!)

Do you have any special fears or concerns about your visit: _____

Describe any previous problems you may have had with past dental treatment or special areas of concern you would like to have addressed by Dr. Schmitt and her staff:
_____

Medication History

□ Yes □ No Are you required to take pre-medication before dental treatment? If yes, for what condition? _____

Please list any medication, herbal supplements, and/or vitamins taken with in the last two years.
_____
_____
_____
_____
_____
_____
_____
_____

□ YES, I have taken oral bisphosphonates.
□ I HAVE NOT TAKEN/DO NOT TAKE ANY MEDICINES OR SUPPLEMENTS.

Check if you are allergic to any of the following:

- □ Aspirin
- □ Ibuprofen
- □ Acetominophen
- □ Penicillin/Amoxicillin
- □ Tetracycline
- □ Erythromycin
- □ Codeine
- □ Local Anesthetics
- □ Metals (gold, stainless steel, _____)
- □ Latex
- □ Any other medicines_____

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Patient's Name _____

Medical & Surgical History

Name of Physician _____ Physician's Phone (___) _____
Physician's Address _____
Date of last visit to physician ____/____/____ Reason for last visit to physician _____
Your current physical health is: ☐ good ☐ fair ☐ poor
WOMAN ONLY: Are you pregnant? _____ If yes, number of weeks ____ Are you nursing? _____

Please check the box if you have had in the **past** or have in the **present** any of the following conditions:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Bones
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Pressure high/low
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Digestive Disorders
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Problems
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pneumocystis
- ☐ Prosthetic Joint
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Please provide additional information and an explanation for those items checked above:
_____
_____
_____

Please describe any serious illnesses and/or operations in the **past 5 years**. Any future treatments or surgeries planned? _____
_____

I give Dr. Schmitt consent to use local anesthetic as needed for my dental treatment **(initial):** _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Schmitt and her staff to help determine appropriate dental treatment. If there are any changes in my medical status, it is my responsibility to inform Dr Schmitt. Since at each visit a treatment plan will be presented and the work to be done is verbally explained to me before treatment is begun, I give Dr. Schmitt my consent to perform any needed dental treatment.
I authorize my insurance company to pay to Stacy Schmitt, DDS, P.A. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize this office to release all information necessary to secure the payment of benefits. **I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.** (Payment is due in full at time of treatment unless prior arrangements have been made.)

Patient/Guardian Signature _____ **Date** ____/____/____

This material is collected solely for the use of this office to process your medical/dental records chart and will be stored in your dental record. This information will be kept confidential by this office and will be disclosed only in accordance with our Notice of Privacy Practices.