Thank you for allowing us to have the opportunity to share in your dental health. In order to help serve you better, please fill out both pages of this confidential health history as accurately as possible.

*It's our pleasure to serve you.* *The team at MySmileCenter*

## Today's Date: ____________

**Patient name:** First________________ Last:________________________ MI_____ Nickname:____________________
**Patient address:** Street________________________________________ City__________________ Zip_______________
**Birthdate:** ___________________ **Age**:____________ **Email**: ________________________________________________
**Phone:** Cell _________________________ Work _________________________ Home ____________________________
**Social Security:** __________________ **Occupation:** ____________________ **Employer:** _________________________
**Marital status:** Single_____ Widowed_____ Married ______ Spouse name ______________________________________

## Responsible party: for treatment/fee decisions (if different than above)

**Patient name:** First________________ Last:_______________________ MI_______ Nickname:_________________
**Patient address:** Street_________________________________ City__________________________ Zip_____________
**Birthdate:** ___________________ **Age**:____________ **Email**: ________________________________________________
**Phone:** Cell _________________________ Work _________________________ Home __________________________
**Social Security:** ______________________**Occupation**: ____________________ **Employer**: ___________________________
**Marital status:** Single☐ Widowed☐ Married ☐ Spouse name _________________________________________

## Patient Benefits:

**Primary** insurance policy number _____________________________ Group number __________________________
Employer________________________ Relation to patient_____________________ Date insured _______
**Secondary** insurance policy number _______________________________Group number ____________________
Employer________________________ Relation to patient_____________________ Date insured ________

***Note:** Insurance is a benefit provided by an insurance company or employer. All policies are different and there is always remaining balance, copay, and/or deductible that is the patient responsibility.

**Communication**: The patient would prefer office communication, appointment reminders by the following:
Email ☐ Text ☐ Phone ☐ Other means? ____________________

**How did you hear about us?**
Website:☐ Mail:☐ Google:☐ Billboard:☐ Social Media:☐ Friend:☐ Insurance:☐ Sign: ☐
Other: _________________ Who can we thank for referring you? ___________________

**Dental History**: **The patients last dental exam was?** _____________ With whom? _________________________
**May we request your dental records?** Yes☐ No☐
***Note**: If you have had work done in another office or by another dentist in the current calendar year of your insurance, the amount of coverage may be affected.

**Your Smile:** **On a scale of 1-10 how do you like your smile?** (circle best answer): 1-2-3-4-5-6-7-8-9-10
**What would you like to change, if anything, about your smile?** _________________________________
Do you know if you grind your teeth? Yes☐ No☐ I don't know☐
Do you smoke? Yes ☐ No ☐ Would you consider stopping to make your mouth healthier?

PLEASE continue on Page 2

## Your Mouth:

**Why are you seeking care at this time?** Routine exam ☐ Cleaning ☐ Broken teeth ☐ Pain ☐
Cosmetic dentistry ☐ Implants ☐ Orthodontics ☐ Invisalign ☐ Jaw issues ☐
Gum therapy ☐ Sedation dentistry ☐ Dentures ☐ Missing teeth ☐
Other reason, please explain: ______________________________

**How are your gums?** Pain ☐ Red ☐ Bleed Easily ☐ Swollen ☐ Abscess ☐
Have you had any of the following? Gum surgery ☐ Deep cleaning ☐
Is there any other treatment you have had for your gums? ______________________________

**Do you have jaw joint problems? TMJ** Yes ☐ No ☐ **Popping or clicking** Yes ☐ No ☐ **Locking jaw** Yes ☐ No ☐
Any history or treatment for jaw or TMJ? ______________________________

## Your Medical History:

Primary care physician name: ______________________________ Phone: ____________________
Are you currently be treated for any condition? ______________________________
Has your physician told you to take antibiotics for dental care? Yes ☐ No ☐ Why? ____________________
Medications, please list: ______________________________
______________________________
Are you pregnant? Yes ☐ No ☐ Trying to become pregnant? Yes ☐ No ☐

**Allergies:** Please circle any of the following that you are allergic to:

Latex Penicillin Codeine Local Anesthetics Aspirin Metals Other allergies: ____________________

## Please circle any of the conditions that you currently have or have had in the past:

| | | |
|---|---|---|
| Abnormal Bleeding | Diabetes Type 1 | Mitral Valve Prolapse |
| Alcohol Abuse | Diabetes Type 2 | Pacemaker |
| Angina Pectoris | Liver Disease | Stroke |
| Arthritis | Drug Abuse | Seizures |
| Artificial Joint | Emphysema | Shingles |
| What joints ____________ | Fever Blisters | Tuberculosis |
| Years____________ | Fainting Spells | Thyroid problems |
| Artificial Heart Valve | Heart Attack | Venereal Disease |
| Year of replacement________ | Year____________ | Kidney Issues |
| Asthma | Hepatitis | Liver Issues |
| Blood Transfusion | Type A B C D | Other____________________ |
| Cancer | Hemophilia | Other____________________ |
| Chemo year ____________ | High Blood Pressure | Other____________________ |
| Radiation year ____________ | HIV/AIDS | Other____________________ |

**Please list any other medical conditions or anything you think we should know about not listed here:**

______________________________
______________________________

Thank you very much for your cooperation in filling out this form. It will never be shared with anyone without your permission and will be used only to improved your dental and overall health. I understand that patient name will be posted in our appointment books, on charts and on schedules posted in treatment areas of the office and that patient privacy will be maintained as much as possible. I also understand that the staff may take photos of treatment that may be used to document treatment and in educational settings by Dr Griffin.

By signing here, you agree that the information is correct, complete, and true.

Print Name:____________________ Signature:____________________ Date:____________

The team at MySmileCenter
*Jack D Griffin, Jr DMD*
*and Associates*