U Smile Family Dentistry
4433 Florin Rd. Ste 790
Sacramento, CA 95823
Ph # : 916-428-0114
Fax # : 916-428-8502

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Student		SSN	
Email				School Name			
				Referral Type			

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N No Change Since Last Recorded
- ☐ Y ☐ N No Known Concerns or Issues
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia / Leukemia
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia / Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma / Hay Fever
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Fainting Spells / Seizures
- ☐ Y ☐ N Fever Blisters / Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Heart Attack / Stroke
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives / Skin Rash
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N High Cholesterol
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently

Other

- ☐ Y ☐ N See Scanned Documents: Pt Note

☐ Y ☐ N AIDS/HIV Infection ☐ Y ☐ N Epilepsy

Dental Questionnaire

Dental Questionnaire

The reason for today's visit? _____

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Do you want to learn to control your dental disease and retain your teeth ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Emergency Contact

Emergency contact name/ relationship to patient _____

Emergency contact phone _____

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operations or been hospitalized?	
If Yes, what illness or problem ?	
Are you currently taking any medication ?	
If Yes, what ?	
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	
Have you ever taken the diet control drug Fen-Phen ?	
Do you use alcoholic beverages ?	
Do you smoke ?	
Women Only	
Are you pregnant? If yes, what is your expected due date?	
Are you currently nursing ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**