AGAVE DENTAL
Smile Esthetics and Wellness

Patient's Name: _____ Sex: M F Birthdate: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

E-mail address: _____

Please Circle One: Single Married Separated Widow

Occupation: _____ Employer: _____

Social Security Number: _____ Are you a full time student: Yes No

Today's Date: _____ Reason for today's visit: _____

How did you hear about our office? _____

Person responsible for account: _____ Relation to patient: _____

Name of spouse (Parent if minor) _____ Employer: _____

Social Security Number: _____ E-mail Address: _____

Cell: _____ Work: _____

Emergency Information:

Name of a relative: _____ Relation to patient: _____

Address: _____ Phone: _____

Dental Insurance Information: Primary

Insured's name: _____ DOB: _____ SS# or ID#: _____

Insured's employer: _____ Insurance Company: _____

Insurance company address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Group #: _____

Secondary

Insured's name: _____ DOB: _____ SS# or ID#: _____

Insured's employer: _____ Insurance Company: _____

Insurance company address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Group #: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.

-Sensitivity (hot, cold, sweet) ☐
Where? UR LR UL LL
-Headaches, earaches, neck pain ☐
-Jaw joint pain ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen or irritated gums ☐
-Loose, tipped or shifting teeth ☐
-Bad breath ☐

Do you have or have you had any of the following?

-Dentures ☐
-Partial dentures ☐
-Braces ☐
-Periodontal (gum) treatments ☐

Please share the following dates:

-Your last cleaning ___/___
-Your last oral cancer screening ___/___
-Your last complete X-Rays ___/___

Name of Previous Dentist _____
City _____ **State** _____
Phone Number _____
What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐
Do you smoke or use chewing tobacco? ☐
How much? For how long?
If I could change my smile, I would: ☐
-Make them whiter ☐
-Make them straighter ☐
-Close spaces ☐
-Replace black metal fillings with tooth colored restorations ☐
-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐
-Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
-Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?
_____
What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS
☐ Allergies (Seasonal)
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart Conditions
☐ Heart Lesions (Congenital)
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Jaw Joint Pain
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervousness/Depression
☐ Pacemaker
☐ Phen Fen (1 month +)
☐ Pregnant Currently
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Seizures
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Venereal Diseases
☐ Other

Do you have any of the following drug allergies?

☐ Aspirin
☐ Darvon
☐ Nitrous Oxide
☐ Percodan
☐ Local Anesthetic
☐ Tetracycline
☐ Codeine
☐ Erythromycin
☐ Valium
☐ Penicillin
☐ Sulfa
☐ Other

Are you under a physician's care? What for?
_____
Are you taking any medications? What?
_____
Family Physician _____ **Phone Number** _____

Patient Signature or Guardian _____ **Date** _____ **Dentist Signature** _____