Hometown Smiles

Patient Name _____ Preferred Name _____

Address _____ City _____ Zip Code _____

Phone _____ DOB ___ /___ /____ Spouse Name _____

Email Address _____

Emergency Contact _____ Emergency Contact Number_____

Preferred Pharmacy _____

Medical History

- ☐ **Anemia**
- ☐ **Arthritis, Rheumatism**
- ☐ **Asthma**
- ☐ **Cancer / Radiation Treatment**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Fainting**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **HIV / AIDS**
- ☐ **Jaw Pain**
- ☐ **Mitral Valve Prolapse**
- ☐ **Osteoporosis**
- ☐ **Sleep Apnea**
- ☐ **Tobacco Habit**

If you checked **YES** to **Heart Problems**, please list your health conditions: _____

_____

Are you currently **pregnant** or **breastfeeding**? ☐ YES ☐ NO

Do you have any artificial Joints? ☐ YES ☐ NO

Have you had any operations within the last year? ☐ YES ☐ NO

Have you ever taken any of the **"bisphosphonates"** such as Fosamax or Prolia? ☐ YES ☐ NO

Are you currently taking **blood thinners** (Plavix, Warfarin, Eliquis)? ☐ YES ☐ NO

MEDICATIONS _____

_____

_____

Medication Allergies

☐ **Aspirin**	☐ **Local Anesthetic**	☐ **Sulfa**	***OTHER*** _____
☐ **Codeine**	☐ **Penicillin**	☐ **Latex**	_____

Dental History

☐ **Bad breath**
☐ **Bleeding gums**
☐ **Clicking or Popping Jaw**
☐ **Do you snore**
☐ **Food Collection between teeth**
☐ **Grinding teeth**
☐ **Loose Teeth or broken fillings**
☐ **Periodontal Treatment**
☐ **Sensitivity to *Cold***
☐ **Sensitivity to *Hot***
☐ **Sensitivity to sweets**
☐ **Sensitivity when biting**
☐ **Sore or growths in your mouth**
☐ **Tension headaches**

Do you have Dental Anxiety? ☐ YES ☐ NO

We offer headphones during your visit to help keep you relaxed, what type of music would you like to listen to? _____

If you could change something about your smile, what would it be? Please Circle.

- Whiter
- Straighter
- Repair chipped teeth
- Replace missing teeth
- New smile design
- Replace old crowns/veneer

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of the staff responsible for any errors that I have made in the complication of this form.

Patient Signature _____ Date: _____

HIPAA RELEASE FORM

I, _____, authorize the release of my dental information from Hometown Smiles in Vero Beach.

This information may be released to (check one):

( ) Spouse _____

( ) Child(ren) _____

( ) Other _____

( ) Information is not to be released to anyone. (Initial Here) _____

In further consideration for this, Hometown Smiles agrees to the same stipulations. This ***Release of Information*** will remain in effect until terminated by me in writing.

Message and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) other _____

The best phone number to reach me at is: _____

Signed: _____ Date: ____ / ____ / ____