



Welcome to The Smile Centre...

All of our Smile Centre offices have been designed to provide a **unique and relaxing environment**. Equipped with the most recent technology and advanced techniques, our treatments are **comfortable, long lasting, and exceed all of your expectations**.

To achieve the best results for you, we provide:

- ❖ **General Dentistry:** Includes all of the traditional dental services and much more to keep your teeth healthy, including implants, root canals, and other procedures that stop obvious decay and missing teeth issues.
- ❖ **Aesthetic Dentistry:** Designed to enhance your smile and create a confident, radiant new look, The Smile Centre has taken this specialty to a new level and was recently recognized by the prestigious Las Vegas Institute (LVI) as a preferred practice for cosmetic and functional dentistry.
- ❖ **Comprehensive Dentistry:** Aligns the way the facial muscles and joints work together while providing proper aesthetics and an improved “bite” to allow you to feel and look younger. We treat problems such as excessive wear, night grinding, and headaches due to migraine or stress; thus assuring that you get the most predictable long-term results.

We look forward to your visit:

Please answer the questions on the next few pages. Your answers will help us prepare for your visit and save you time later. If you have any questions, you may visit our Web site or call us: Sarasota, 941-351-4468 or Venice, 941-497-5451.

Returning the questionnaire:

Bring them with you for your first appointment or,

Via Fax:

You may also print the forms on your printer, fill them out and fax the completed forms to The Smile Centre: 941-351-9361

On behalf of our Smile Centre team,

Sincerely,
Richard A. Stanley, D.M.D.



Dental History

Date _____

Guest Name _____ Preferred Name _____

Work/ Retired from _____

Hobbies _____

What if any problems are you having right now?

Sensitivity: Yes / No Hot Cold Bite Sweets Other _____

When was your last dental visit? _____ What was done? _____

How would you rate the health of your teeth and gums on a scale of **1 to 10**? _____

Are you able to eat everything you want? Yes / No _____

What is most important to you about your teeth? _____

How would you rate how happy you are with your smile on a scale of **1 to 10**? _____

Are you ever self-conscious about your smile? Yes / No

What about your teeth/smile is not as nice as you would like it to be?

If you could have your mouth any way you want it, what would it be like?

Do you have any concerns about your old metal / mercury fillings? Yes / No

Have you been told you have gum disease or pyorrhea? Yes / No

What kind of gum treatment have you had in the past? None

How do you take care of your teeth? Manual Brush Electric Brush Floss
Irrigator Tongue Cleaner Rinse

Do you have bleeding when you brush or floss? Yes / No

Does food get caught between your teeth? Yes / No

Do your jaws ever: Pop Noise Pain Lock Open Lock Close

Are you aware of clenching during the day or grinding at night? Yes / No

Have you ever been told you grind your teeth at night? Yes / No

Do you have a bite guard? Yes / No Use it when? _____

Have you ever had sedation for your dental treatment? Yes / No

Is there anything else we could do or not do to make your visits absolutely perfect?

Is there anything that would prevent you from having treatment now?

Would longer appointments work better for you if it meant fewer visits? Yes / No

Have you given any thought as to a lifetime budget for your dentistry?



Patient Registration

Last Name _____ First Name _____ Middle Initial _____
Street Address _____ Apt/Unit _____
City, State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____

Birth Date ____/____/____ Age ____ Sex ____ Marital Status ____
Social Security No. ____ - ____ - ____

Occupation _____ Employer _____
Business Address _____
Business Phone _____ Ext _____

Personal Information

Referred to us by _____
In case of emergency, please contact:
Name _____ Home Phone _____
Address _____ City/State _____
Relationship _____

Dental Insurance Information (if applicable)

Primary Carrier: Ins Co _____
Employee Name _____
Employer _____
Group No _____ Local No _____
Date Employed _____ Employee Social ____ - ____ - ____
Employee Birthdate ____/____/____

Secondary Carrier: Ins. Co _____
Employee Name _____
Employer _____
Group No _____ Local No _____
Date Employed _____ Employee Social ____ - ____ - ____
Employee Birthdate ____/____/____

Account Information

Person financially responsible for account: Self ____ Spouse ____ Other ____
If other than self, please complete the following information:

Name _____ Relation to Patient _____
Occupation _____ Employer _____
Business Address _____
Business Phone _____ Ext _____

Patient/Guardian Signature _____ Date _____

Medical History Information

Have you been under the care of a medical doctor during the past two years? Yes No
 Physician's Name _____
 Address _____
 Phone _____
 Have you been a patient at the hospital during the past two years? Yes No
 Have you taken any medication or drugs during the past two years? Yes No
 Are you now taking any medication, drugs or pills, including aspirin? Yes No
 If yes, please list: _____
 Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? Yes No
 If yes, please list: _____
 Are you having pain or discomfort at this time? Yes No

Indicate which of the following you have had or have at present. Circle "yes" or "no" next to each item.

Heart Failure	Yes	No	Stroke	Yes	No	Have you seen a Acupuncturist?	Yes	No
Heart Disease or Attack	Yes	No	Artificial Joints	Yes	No	Have you seen a Chiropractor?	Yes	No
Angina Pectoris	Yes	No	Kidney Trouble	Yes	No	Have you seen a Neurologist?	Yes	No
Congenital Heart Disease	Yes	No	Ulcers	Yes	No	Have you seen an ENT?	Yes	No
Heart Murmur	Yes	No	Diabetes	Yes	No	Bite feels off	Yes	No
High Blood Pressure	Yes	No	Thyroid Problems	Yes	No	Neck/Back Pain	Yes	No
Arteriosclerosis	Yes	No	Glaucoma	Yes	No	Have you taken Prednisone?	Yes	No
Mitral Valve Prolapse	Yes	No	Cosmetic Surgery	Yes	No	Temporal Arteritis	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Facial Muscle Pain	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Over closed mouth	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Ringing in ears	Yes	No
Rheumatic Fever	Yes	No	Allergies or Hives	Yes	No	Fainting or Dizzy Spells	Yes	No
Arthritis	Yes	No	Epilepsy or Seizures	Yes	No	Nervousness	Yes	No
Rheumatoid Arthritis	Yes	No	Radiation Therapy	Yes	No	History of Depression	Yes	No
Yellow Jaundice	Yes	No	Chemotherapy	Yes	No	Headaches/ Migraines	Yes	No
Cortisone Medicine	Yes	No	Hepatitis A (infectious)	Yes	No	Jaw Popping	Yes	No
Drug Addiction	Yes	No	Hepatitis B (serum)	Yes	No	Limited Opening	Yes	No
Smoker	Yes	No	Hist. of Cancer/Tumor	Yes	No	Sinus Trouble	Yes	No
Liver Disease	Yes	No	Bruise Easily	Yes	No	Pain in Jaw Joints	Yes	No
Sickle Cell Disease	Yes	No	Hemophilia	Yes	No	Obstructive Sleep Disorder	Yes	No
Anemia	Yes	No	Blood Transfusion	Yes	No	Insomnia	Yes	No
A.I.D.S./ H.I.V. Positive	Yes	No	Venereal Disease	Yes	No	Sleep Apnea	Yes	No
						Snoring	Yes	No

Do you have or ever had any disease, condition, or problem not listed? (If yes please list:) Yes No
 Do you use more than two pillows to sleep? Yes No
 Do you ever wake up from sleep and feel short of breath? Yes No
 Do your ankles swell during the day? Yes No
 If you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Yes No
 Are you on a special diet? Yes No
 Have you lost or gained more than 10 pounds in the past year? Yes No

Women Only: Are you pregnant? **Yes** ١٢ **No** ١٣ Are you nursing? **Yes** ١٤ **No** ١٥ Are you taking birth control pills? **Yes** ١٦ **No** ١٧

I find the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Consent for examination (only)

The undersigned hereby authorizes Doctor to take X-rays, study models, photos, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employee such assistance as deemed fit.

I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for all services provided in this office for me or my dependents is mine, due and payable at the time services are rendered unless written and signed financial arrangement has been made. I further understand that any insurance reimbursement is my responsibility and that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (We) agree to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Sign _____ Date _____
 Witness _____