

Softouch Dental Care - *Changing Lives One Smile at a Time*

Name: _____
(Last) First MI Social Security # Date of Birth
 Male Female Married Single Child Other

Phone: _____
Home Work Cell

Address: _____
City State Zip Code

Employer: _____

Address: _____ Occupation: _____

City,St,Zip _____

Email: _____ May we contact you by email? Yes No

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason For Visit: _____

Have you ever had any of the following? Please check **ALL** that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Premed Abio/PrevntSBE |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Growths | <input type="checkbox"/> Premed Valium/Xanax |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> ProstheJoint-premed |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergy - Erythromycin | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergy - Nickel | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Highly Anxious | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergy - Tetracycline | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Allergy - OTHER _____ | <input type="checkbox"/> Hormone Replacement | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HX Dental Trauma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HX Perio Surgery | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Aspirin Therapy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Avoid Epi / Use Carbo | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Blood Disease / Thinner | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Coumadin / Blood Thinners | <input type="checkbox"/> Needle Phobia | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorders | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pregnancy | _____ |
| <input type="checkbox"/> Excessive Bleeding | Due Date: _____ | _____ |
| <input type="checkbox"/> Fainting | | |

In the event of an Emergency, whom should we contact? _____ Tel: _____

General Health (Please circle): EXCELLENT GOOD FAIR POOR

Name of Physician: _____ Telephone: _____

Are you currently under the care of a physician? Yes No

Do you have any health problems that need further clarification? _____

On a scale of 1-10 (10 being very satisfied and 1 being very dissatisfied) how would you rate your smile? _____

REFERRAL INFORMATION: Whom may we thank for referring you to our Practice? _____

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Our Website | <input type="checkbox"/> Las Vegas Institute (LVI) | <input type="checkbox"/> Radio: WTOP | <input type="checkbox"/> NBC News Channel 4 | <input type="checkbox"/> New Beauty Magazine |
| <input type="checkbox"/> Cosmeticdentistry.com | <input type="checkbox"/> 1-800-BEST-DDS | <input type="checkbox"/> Radio: WMAL | <input type="checkbox"/> Television/Cable | <input type="checkbox"/> Washingtonian Magazine |
| <input type="checkbox"/> Aboutcosmeticdentistry | <input type="checkbox"/> Cheesecake Factory | <input type="checkbox"/> Radio: WASH-FM | <input type="checkbox"/> Newsletter | <input type="checkbox"/> DentaLife Magazine |
| <input type="checkbox"/> Current Patient | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Radio: Smooth Jazz | <input type="checkbox"/> Red-Book | <input type="checkbox"/> |

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

PRINT NAME _____

Date: _____

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Signature of Guest, Parent or Guardian