PAIGE PRATHER SMILES
DR. PAIGE PRATHER

DENTAL HISTORY UPDATE

Please check any of the following that apply to you:	YES	NO	If I could change my smile, I would:	YES	NO
Sensitivity (Hot, Cold, Sweet)	□	□	Make Them Whiter	□	□
If so, Where: UR LR UL LL			Make Them Straighter	□	□
Headaches, Earaches, Neck Pain	□	□	Close Spaces	□	□
Jaw Joint Pain	□	□	Replace Black Metal Fillings with Tooth		
Teeth or Fillings Breaking	□	□	Colored Restorations	□	□
Grinding or Clenching Teeth	□	□	Repair Chipped Teeth	□	□
Bleeding, Swollen or Irritated Gums	□	□	Replace Missing Teeth	□	□
Loose, Tipped or Shifting Teeth	□	□	Replace Old Crowns that Don't Match	□	□
Bad Breath	□	□	Have a Smile Makeover	□	□

On a Scale of 1-10, with 10 Being the Highest:

How Important is your Dental Health to you? _____

Where Would you Rate your Current Dental Health? ____

Do you smoke or use chewing tobacco?_____

What is the most important thing to you about your dental health and your visit today? _____

If so, how much? _____ **How Long?**_____

MEDICAL HISTORY UPDATE

Please Check Any of the Following That Apply to You:

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

For WOMEN Only

□ Birth Control Pills □ Breast Feeding □ Pregnant - If Pregnant, □ 1-3mos □ 3-6mos □ 6-9mos

Do you have any of the following drug allergies?

□ Aspirin □ Penicillin □ Darvon □ Codeine □ Erythromycin □ Valium □ Local Anesthetic □ NKDA

Other:_____

Please List ALL Medications you are Currently Taking:

❑ NONE

_____

_____

Are you currently under a physician's care? What for?

_____

_____

_____

Name of Physician: _____ **Phone number:**_____

Other Medical or Dental Information We Should Know About:

_____

To the best of my knowledge, this information is true and correct. I know if I have any changes in my health it is my responsibility to inform my provider.

Print Patient Name:_____Signature:_____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name:_____ Date of Birth:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical/dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Paige Prather Smiles to release my medical/dental and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____ Date:_____