380 E. Virginia Ave.
Phoenix, AZ 85004
(602)277-2222
info@radiantsmilephx.com

WELCOME

Thank you for choosing our office. Our goal is to provide optimal care in a comfortable and truly patient-centered environment. We promise to listen to your treatment goals and concerns and to provide care without pressure. At Radiant Smiles Phoenix, we treat you like family and your answers are for our records only. So that we may provide exceptional care for you, please tell us about yourself:

About You

* Required

Patient Name* _____ Preferred to be called* _____
Last First MI

Address* _____

Email* _____

Cell Phone* _____ Home Phone* _____

Preferred Method of Contact ❒ Phone Call ❒ Text Message ❒ Email ❒ All Listed

Date of Birth* ____/____/ (mm/dd/yyyy) SSN/ID* _____

Marital Status ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Sex ❒ Male ❒ Female

Occupation* _____

Employer* _____ Work Phone* _____

Emergency Contact

Name* Phone*

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- ❒ Heart Problems/Congestive Heart Disease
- ❒ Allergic to Penicillin/Amoxicillin
- ❒ Allergic to Tetracycline
- ❒ Allergic to Aspirin
- ❒ Allergic to Codeine
- ❒ Allergic to Novocain
- ❒ Allergic to Latex Rubber
- ❒ Pre-medication required
- ❒ Mitral Valve Prolapse
- ❒ Pacemaker
- ❒ HIV Positive
- ❒ Heart Murmur
- ❒ Heart Attack
- ❒ Chest Pain
- ❒ Congenital Heart Problem
- ❒ Artificial Heart Valve
- ❒ Heart Surgery
- ❒ High/Low Blood Pressure
- ❒ Rheumatic Fever
- ❒ Anemia
- ❒ Blood Disease
- ❒ Blood Transfusion
- ❒ Stroke
- ❒ Deep Vein Clot
- ❒ Hemophilia
- ❒ Excessive Bleeding when cut
- ❒ Sickle Cell Disease
- ❒ Glaucoma
- ❒ Diabetes (type 1 or 2)
- ❒ Excessive Thirst
- ❒ Scarlet Fever
- ❒ Thyroid Disease
- ❒ Parathyroid Disease
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Hepatitis A or B or C
- ❒ Cancer, Type:_____
- ❒ X-Ray or Cobalt Treatment
- ❒ Chemotherapy
- ❒ Ulcers
- ❒ Gastrointestinal Upset
- ❒ Acid Reflux
- ❒ Lung Disease
- ❒ Tuberculosis
- ❒ Shortness of Breath
- ❒ Emphysema
- ❒ Asthma
- ❒ Sinus Trouble
- ❒ Hay Fever
- ❒ Frequent Cough
- ❒ Rheumatism
- ❒ Arthritis/Gout
- ❒ Osteoporosis
- ❒ Swelling of Feet/Ankles
- ❒ Artificial Joint Replacement: Year:_____Type: _____
- ❒ Psychiatric Care
- ❒ Epilepsy or Seizures
- ❒ General Anxiety/Dental Phobia
- ❒ Fainting or Dizziness
- ❒ Hypoglycemia
- ❒ Hives
- ❒ Cold Sores/Fever Blisters/Herpes
- ❒ Venereal Disease
- ❒ HPV (Human Papillomavirus)
- ❒ Cortisone Treatment
- ❒ Chemical Dependency
- ❒ Other: _____

Please list current medications here

Physician Information

Are you currently under a physician's care? * ❒ Yes ❒ No

Physician Name & Address _____

_____

If yes, for what?

Hospitalization Information: If you have been hospitalized in the last two years, for what? *

Do you smoke or use tobacco? * *(Mark only one)* ❒ Yes ❒ No

If yes: how many packs per day_____ Number of years as a smoker _____

Are you pregnant? * *(Mark only one)* ❒ Yes ❒ No

If yes, what is your due date?_____/____/_____(mm/dd/yyyy)

Are you taking birth control pills? * ❒ Yes ❒ No

Are you on hormone therapy? * ❒ Yes ❒ No

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Dental History

What is your primary reason for seeking dental care?

Previous Dentist's Information		
Dentist's Full Name		
Name of Dental Practice		City & State
Month and Year of last visit		
What was done at last visit?		
Date of last full mouth X-rays	/ / (mm/dd/yyyy)	
Reason for leaving last dentist		

Do You / Are You?

Check all that apply.

- ❒ Nervous about dental treatment?
- ❒ Gag easily?
- ❒ Sensitive to hot, cold, pressure or sweets?
- ❒ Have problems with teeth/fillings breaking?
- ❒ Have an uncomfortable bite?
- ❒ Have gums that are tender and/or bleed?
- ❒ Get food lodged between teeth often?
- ❒ Have periodontal (gum) treatments in the past?
- ❒ Get sores in or around the mouth?
- ❒ Get regular headaches, earaches or neck pain?
- ❒ Grind or clench your teeth?
- ❒ Hear a "clicking" sound when you open/close your mouth?
- ❒ Have a jaw that sometimes gets "stuck"?
- ❒ Have TMJ Jaw Disorder?
- ❒ Have sleep apnea?
- ❒ Have mouth sores that take long to heal?
- ❒ Have dry mouth?
- ❒ Have excessive bleeding after an extraction?
- ❒ Take Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia, Zometa?
- ❒ Unhappy with the appearance of your teeth?
- ❒ Brush at least once daily?
- ❒ Want whiter teeth?
- ❒ Want straighter teeth?
- ❒ Have dentures (partials or full)?
- ❒ Other: _____

So that we can provide exceptional care, is there anything else we should know?

Mark only one (5 is best)

How do you feel your overall dental health is?	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
How proactive would you like to be regarding your dental health?	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
What is your level of sensitivity to dental procedures?	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
What is your level of anxiety regarding dental procedures?	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5
How do you feel about your smile and the look of your teeth?	❒ 1	❒ 2	❒ 3	❒ 4	❒ 5

If there were anything that you would like to change about your teeth or your smile, what would that be? Please explain below:

Dental Insurance

Do you have dental insurance? * *(Mark only one)* ❒ Yes ❒ No			
If you have dental insurance, please complete the following:			
Name of Insured			
Date of Birth	____/____/____(mm/dd/yyyy)	Relationship to patient	
Dental Insurance Company			
Group number		ID #	

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Parkview Dentistry of Arizona PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize the dentist to perform any necessary examination and radiographs needed for proper diagnosis.

Responsible Party Signature:_____ Date: _____

Relationship to Patient: _____

Referral Information

We would love to have the opportunity to thank the person or people that have referred you to our office:

Who can we thank for referring you to our office? * _____

- ❒ Google search
- ❒ Facebook®
- ❒ Other: _____