Paulette Soltis-Hamilton DMD
Family and Cosmetic Dentistry

Welcome,

We are happy you chose our office. Our team is dedicated to providing high-quality dental care in a warm and welcoming environment.

We understand that visiting the dentist can sometimes be intimidating, but we're here to make sure you feel comfortable and at ease throughout your visit. Our team members are friendly and professional, and we'll do everything we can to make sure your experience with us is a positive one.

If you have any questions or concerns, please do not hesitate to ask. Our staff is here to help you achieve and maintain optimal oral health, and we are happy to answer any questions you may have.

We look forward to working with you and helping you achieve a healthy and beautiful smile.

Patient Information

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Homephone/ Cell Phone: _____

Email: _____ Please Check Appropriate Box: ☐ Minor ☐ Divorced

If student, Name of School/College: _____ ☐ Single ☐ Widowed

☐ Married ☐ Seperated

☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer: _____

Business Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____

Spouse or Parent/Guardian's Name: _____

Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____

Person to contact in case of Emergency: _____

Relationship: _____ Phone Number: _____

Responsible Party

Name of Person Responsible for this account: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Homephone/ Cell Phone: _____

Email: _____ Is this person a patient at our office? ☐ Yes ☐ No

Employer: _____ Work Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#SIN: _____

Insurance Company Name: _____ Group Name: _____

Group #: _____ Policy/ID#: _____

Patient Name: .....

Physician: _____ Office Phone: _____ Date Of Last Exam: _____

1. Are you under any medical treatment now? _____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:

_____

_____

3. Are you taking any medication(s), including prescription and non-perscription medications? If yes, please list all medications below: _____

_____

_____

4. Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/ Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/ Convulsions	☐	☐	Cancer	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
Kidney Diseases	☐	☐	Hepatitis/ Jaundice	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS/HIV	☐	☐	Sexually Transmitted Disease	☐	☐	Other:		
Thyroid Problem	☐	☐	Stomach Troubles/ Ulcers	☐	☐	.....		
Drug Addictions	☐	☐	Chemotherapy	☐	☐			
Blood Disorders	☐	☐	Psychiatric Care/Treatment	☐	☐			

	Yes	No
5. Have you ever taken Fen-Phen/Redux?	☐	☐
6. Have you taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
7. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
8. Do you use tobacco/chew/vape?	☐	☐
9. Do you use controlled substances?	☐	☐
For Women:		
Are you pregnant?	☐	☐
If yes when are you due? _____		
Are you nursing?	☐	☐
Are you using any form of birth control?		

_____

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. Novocaine)	☐	☐
If yes, please list:		
_____		
Penicillin or ANY other Antibiotics	☐	☐
If yes please list:		
_____		
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)		

_____

Please Turn Page Over

Patient Name: .....

Patient Dental History

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot and cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet/ sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any lumps or bumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries/surgery?	☐	☐

7. Have you every experienced any of the following problems with your jaw? Please Check all that apply :

- Clicking ☐
- Pain (joint, ear, face) ☐
- Difficulty in opening and closing ☐
- Difficulty in chewing ☐
- Do you have a diagnosed history of TMJ Issues? ☐
- Do you have a history of gum disease? ☐
- Do you have a history of mouth breathing? ☐
- Nail biting? ☐
- Holding objects with your teeth ☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench and grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding follwing extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐

If yes, date of placement _____

15. Have you ever recieved oral hygiene instructions? ☐ ☐

16. Do you like your smile? ☐ ☐

17. Date of Last X-rays? _____

18. Are you having pain or discomfort at this time? Chief complaint: _____

19. How would you describe your present dental health? Please **Check** one: GOOD ○ FAIR ○ POOR ○

20. Have you ever experienced unfavorable reaction to previous dental treatment? (anesthetic reaction/pain?). ☐ ☐

21. Do you feel your teeth are ☐ crowded, ☐ poorly aligned, ☐ protruding?

22. Are you interested in correcting any malalignment of your teeth? ☐ ☐

23. Are you hiding your teeth when smiling? ☐ ☐

24. Are you happy with the color of your teeth? ☐ ☐

25. Do you have fractures in your front teeth? ☐ ☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date

Signature of patient (or parent/guardian if minor)