Leonard S. Scott, DDS & Lynna C. Scott, DDS
Where your smile is your greatest asset!

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address (Street, City, State, ZIP) _____

Date of birth _____ Age _____ Social security no. _____

Home phone (___) ___ - _____ Work phone (___) ___ - _____ Cell phone (___) ___ - _____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Fax (___) ___ - _____

E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's date of birth _____

Spouse's social security no. _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone _____

Grade _____ Social security no. _____

Payment is due in full at the time of treatment
(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ *Date* _____

Dental History

Reason for today's visit _____

Date of last full mouth X-rays _____

Date of last dental visit _____ Date of last cleaning _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

How often do you have dental examinations? _____

How often do you brush your teeth? _____

What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

How often do you floss? _____

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you have any dental problems now? _____

If yes to above, please describe _____

Do your gums ever bleed?	☐ Yes	☐ No
Have you ever had periodontal disease?	☐ Yes	☐ No
Have you ever had gum treatment?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you still have your wisdom teeth?	☐ Yes	☐ No
Do you have any dental problems now?	☐ Yes	☐ No

If yes, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

_____

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral surgery?	☐ Yes	☐ No
Periodontal treatment?	☐ Yes	☐ No
Your teeth ground or bite adjusted?	☐ Yes	☐ No
A bite plate or mouthguard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

If so, please describe _____

_____

Medical History

Have you been under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Physician's name _____ Phone _____

Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain _____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Did you ever go to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No

Do you use alcohol or any other controlled substance? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had or have at present:

☐ Yes	☐ No	AIDS	☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Alcohol/Drug Abuse	☐ Yes	☐ No	Hemophilia/Abnormal Bleeding
☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Hepatitis A B C (circle)
☐ Yes	☐ No	Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure
☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No	HIV Positive
☐ Yes	☐ No	Artificial Bones/Joints/Valves	☐ Yes	☐ No	Hospitalized for Any Reason
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney Trouble
☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No	Latex Sensitivity
☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Cancer/Chemotherapy	☐ Yes	☐ No	Low Blood Pressure
☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Cold Sores/Herpes	☐ Yes	☐ No	Mitral Valve Prolapse
☐ Yes	☐ No	Colitis	☐ Yes	☐ No	Nervous/Anxious
☐ Yes	☐ No	Congenital Heart Disease	☐ Yes	☐ No	Neurological Disorders
☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Psychiatric/Psychological Care
☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Radiation Therapy
☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Rheumatic/Scarlet Fever
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Diet (Special/Restricted)	☐ Yes	☐ No	Sickle Cell Disease/Traits
☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Sinus Trouble
☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Swollen Ankles
☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Thyroid Problems
☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Tuberculosis (TB)
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Tumors
☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Yellow Jaundice

Please list any serious medical condition(s) that you have ever had not listed above:

_____

Are you aware of having an allergic (or adverse) reaction to any of the following:

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Latex
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Penicillin or Other Antibiotics
☐ Yes	☐ No	Anesthetics (for example Novocaine)	☐ Yes	☐ No	Sedatives
☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Sulfa Drugs
☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Other _____

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient

Date of birth _____ Insured's social security no.

Insured's employer name _____

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient

Date of birth _____ Insured's social security no.

Insured's employer name _____

Person Financially Responsible for Account

Name _____ Relationship to patient _____

Social security no. _____ Phone _____

Driver's license no. _____ Date of birth _____

Address (Street, City, State, ZIP) _____

Employer _____

Preference of payment: ☐ Cash ☐ Credit Card

Visa/MC/AMEX no. _____ Exp. date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Doctor's comments:

_____

_____

_____

_____

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Getting to know a little more about you...

Thank you for being a part of our dental family. To get to know you even better, please tell us a few more things about yourself.

Do you have any special dates you like to remember? (weddings, graduations, etc.)

Event _____ Date _____

Event _____ Date _____

Event _____ Date _____

Event _____ Date _____

Do you have children and grandchildren?

Name	Age	Check one	Special accomplishments or recognition you'd like to share?
_____	_____	☐ Child ☐ Grandchild	_____
_____	_____	☐ Child ☐ Grandchild	_____
_____	_____	☐ Child ☐ Grandchild	_____
_____	_____	☐ Child ☐ Grandchild	_____
_____	_____	☐ Child ☐ Grandchild	_____
_____	_____	☐ Child ☐ Grandchild	_____

Do you have any pets?

Name	Type (dog, cat, bird, etc.)	Breed
_____	_____	_____
_____	_____	_____
_____	_____	_____

What type(s) of music do you enjoy? (check all that apply)

☐ Easy Listening ☐ Classical ☐ Rock ☐ Hip-Hop/Rap
☐ Jazz ☐ Country ☐ R&B ☐ Other:_____

What are your favorite hobbies or activities? (check all that apply)

☐ Golf ☐ Running ☐ Art ☐ Reading
☐ Tennis ☐ Team Sports ☐ Photography ☐ Other:_____
☐ Cycling ☐ Water sports ☐ Gardening

When you travel, where do you like to go? (check all that apply)

☐ Beaches ☐ Cruises ☐ Other: _____
☐ Cities ☐ Road trips

About your smile, and more...

We want to help you achieve your ideal smile. The following will help us understand what that means to you.

1. I love the way my smile looks: ☐ True ☐ Somewhat true ☐ Not true

2. I feel comfortable showing my teeth when I laugh or smile: ☐ True ☐ Somewhat true ☐ Not true

3. If I could change anything about my smile it would be (check all that apply):

☐ Color of my teeth
☐ Size of my teeth
☐ Shape of my teeth
☐ Too much or too little of teeth show when I smile
☐ Too much or too little of gum shows when I smile
☐ Other: _____
☐ Gaps between my teeth
☐ Alignment of my teeth

4. I have (check all that apply):

☐ Sensitive or receding gums
☐ Missing teeth
☐ Broken/chipped teeth
☐ Old or discolored fillings
☐ Old crowns that have dark edges at the top
☐ Other: _____

5. In my line of work or lifestyle I often (check all that apply):

☐ Visit businesses or clients
☐ Speak publicly
☐ Travel
☐ Minimal interaction with others
☐ Other:_____

6. If I had a smile makeover I would feel (check all that apply):

☐ More confident
☐ Just OK
☐ More optimistic
☐ No different
☐ Healthier
☐ Other: _____

7. I would like to know about how dentistry can help with one or more of these issues regarding myself or someone in my family (check all that apply):

☐ Chronic bad breath
☐ Sports mouthguards
☐ Grinding teeth
☐ Snoring
☐ Other: _____

8. I prefer appointments in the (check all that apply):

☐ Early morning
☐ Late morning
☐ Early afternoon
☐ Late afternoon
☐ No preference
☐ Other: _____

9. The most important features I want in a dental office are (check all that apply):

☐ Convenient location
☐ Preventative care
☐ Comfortable atmosphere
☐ Long-lasting results
☐ Convenient appointment times
☐ Treatment choices
☐ Caring and attentive staff
☐ Low-to no-pain dentistry
☐ Short appointments
☐ State-of-the-art technology and treatment
☐ Minimal change in appearance during treatment
☐ Other: _____

10. Is there anything else that you want our office to know about you that will help us to serve you better?

_____

_____

_____

_____

_____

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Health History Update – Existing Patients Only

Please let us know if any of the following contact information has changed:

Today's date _____ **Patient Number** _____

First name _____ Middle initial _____ Last name _____

Address _____ City _____ State _____ ZIP _____

Home phone (___) ___ - _____ Work (___) ___ - _____ Cell (___) ___ - _____

E-mail _____ Fax (___) ___ - _____

Anything else we should know? _____

_____

Health changes: Date health change occured _____

_____

_____

_____

Physician's name _____ Physician's phone _____

Current medications

_____

_____

_____

_____

Last physical exam _____ Any allergies? _____

_____ Signature _____ Staff initials _____

Health changes: Date health change occured _____

Physician's name _____ Physician's phone _____

Current medications

_____

_____

_____

_____

Last physical exam _____ Any allergies? _____

_____ Signature _____ Staff initials _____