Prestonwood Dental
We're All About Smiles

Shweta G. Daftary, DDS

Patient Information *(Confidential)*

Today's Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse/Parent's Name _____ Employer _____ Work Phone _____

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Person to Contact in Case of Emergency _____

Relationship to Patient _____ Phone _____

Whom Shall We Thank For Your Referral _____

Appointment Reminder ☐ via Email ☐ Phone call ☐ SMS/Text Message (Phone Carrier) _____

Responsible Party

Name of Person responsible for this Account _____ Relationship to Patient _____

Address _____ Phone _____

Employer _____ Phone _____

Driver's License# _____ Birthdate _____ SS# _____

Insurance Information *(All about insured)*

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Phone _____

Insurance Company _____ Phone _____

Name of Employer _____ Phone _____

Smile Analysis

Ask Dr. Daftary how you can transform your smile from dull to dazzling!

	Yes	No
Do you feel that your teeth are too small or too large?	☐	☐
Have your gums receded?	☐	☐
Do you show too much gum tissue when you smile?	☐	☐
Are you unhappy with any crowns in your mouth?	☐	☐
Are your teeth crooked, mis-shapen, or out of line?	☐	☐
Are the biting edges of your teeth worn down?	☐	☐

	Yes	No
Are there spaces between your teeth?	☐	☐
Do your teeth slant one way or another?	☐	☐
Are your teeth dull, dark, or stained?	☐	☐
Are any of your teeth missing?	☐	☐
Are any of your teeth that have old fillings, stained blue or gray?	☐	☐

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Patient Medical History

Physician _____ Office Phone _____

Are you currently under any medical treatment? If yes, please explain _____

_____

Have you ever been hospitalized for any surgical treatment or illness in the past 5 years? _____

_____

Are you currently taking any medications, including over the counter medications? Please list all _____

_____

Do you have or have you had any of the following? Please check all that apply.

Asthma ☐	Glaucoma ☐	Rheumatic Fever ☐
AIDS or HIV infection ☐	High blood pressure ☐	Radiation Therapy ☐
Anemia ☐	Heart Murmur ☐	Recent weight loss ☐
Angina ☐	Heart Disease/Heart Attack ☐	Stroke ☐
Artificial Heart Valve ☐	Hepatitis/Jaundice ☐	Stomach troubles/Ulcers ☐
Arthritis ☐	Joint Replacements/Implants ☐	Sexually Transmitted Diseases ☐
Cardiac pacemaker ☐	Kidney Diseases ☐	Tuberculosis ☐
Cancer ☐	Liver Diseases ☐	Thyroid Problems ☐
Diabetes ☐	Low blood pressure ☐	For Women:
Epilepsy ☐	Leukemia ☐	Are you pregnant? ☐
Emphysema ☐	Mitral Valve Prolapse ☐	Due date _____
Fainting/ Seizures ☐	Respiratory Problems ☐	Are you Nursing? ☐

Others _____

Allergies to any medications _____

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 or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sore or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any clicking or pain in the TMJ area, difficulty in opening or closing of your jaw?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently	☐	☐
11. Have you ever had any difficult extractions or prolonged bleeding from it in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partial? If yes, date of placement _____	☐	☐

Authorization and Release

- I certify that I have read and understood 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. If I have any changes in my health, I will inform Dr. Daftary at my next appointment.
- I authorize Dr. Daftary and her staff to take x-rays, models, photos and/or other diagnostic aids necessary for a thorough oral diagnosis of myself and/or my minor dependent listed on this form.
- I also authorize Dr. Daftary to release any such information to third party payors and/or healthcare practitioners for the purpose of rendering treatment, payment activities and healthcare operations.
- I understand and acknowledge that Dr. Daftary may use my photographs in her marketing campaign for educational purposes to potential patients.
- I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I authorize and request my insurance company to pay directly to Dr. Daftary, the insurance benefits otherwise payable to me.

Signature of patient/parent of minor _____ Date _____

Medical Update (for office use only) _____

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