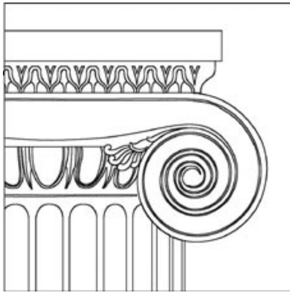


WELCOME TO THE OFFICE OF DR. KEITH BLESSITT
AESTHETIC COMPREHENSIVE DENTISTRY

WWW.WEMAKESMILES.COM
954.476.4537

ABOUT YOU

Date: ____________________

First Name: ____________________ Last Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip Code: __________ Country: ____________

Birth date: ____/____/____ Social Security #: ____________ Sex: ◯ M ◯ F Marital Status: ◯ M ◯ S ◯ D ◯ W

Driver's License #: ____________ State: ________ Valid Thru: ____________

Home Phone #: ____________ Cell Phone #: ____________ Work Phone #: ____________

E-mail address (email info for our office use only): ____________________

PARENT / SPOUSE

Spouse Name: ____________ Spouse's Place of Employment: ____________

Person responsible for account (if child, put parent's name): ____________________

Address (if different from above): ____________________

City: ____________ State: ________ Zip Code: __________ Country: ____________

Employer: ____________ Position: ____________ Student ?: ◯ Y ◯ N Where?: ____________

Work Address: ____________________

City: ____________ State: ________ Zip Code: __________ Country: ____________

EMERGENCY INFO

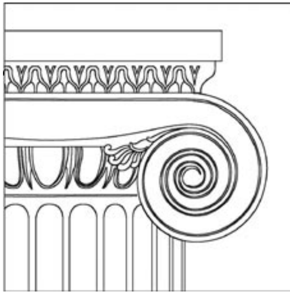
Name of nearest relative not in same household: ____________ Relationship: ____________

Address: ____________________

City: ____________ State: ________ Zip Code: __________ Country: ____________

Relatives Contact phone number: ____________________

Who may we thank for referring you to our office? ____________________



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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around you mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now? ○Y ○N If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ○Y ○N If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ○Y ○N If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ○Y ○N If yes, please explain: ______________________

Do you take, or have taken, Phen-Fen or Redux? ○Y ○N

Are you on a special diet? ○Y ○N

Do you use tobacco? ○Y ○N

Do you use controlled substances? ○Y ○N

Women : Are You

Pregnant/Trying to get pregnant? ○Y ○N

Taking oral contraceptives? ○Y ○N

Nursing? ○Y ○N

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics

○ Other If yes, please explain: ______________________

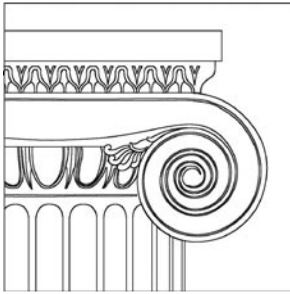
Do you have, or have you had, any of the following?

Condition	Y	N
AIDS/HIV Positive	○Y	○N
Alzheimer's Disease	○Y	○N
Anaphylaxis	○Y	○N
Anemia	○Y	○N
Angina	○Y	○N
Arthritis/Gout	○Y	○N
Artificial Heart Valve	○Y	○N
Artificial Joint	○Y	○N
Asthma	○Y	○N
Blood Disease	○Y	○N
Blood Transfusion	○Y	○N
Breathing Problem	○Y	○N
Bruise Easily	○Y	○N
Cancer	○Y	○N
Chemotherapy	○Y	○N
Chest Pains	○Y	○N
Cold Sores/Fever Blister	○Y	○N
Congenital Heart Disorder	○Y	○N
Convulsions	○Y	○N
Cortisone Medicine	○Y	○N
Diabetes	○Y	○N
Drug Addiction	○Y	○N
Easily Winded	○Y	○N
Emphysema	○Y	○N
Epilepsy or Seizures	○Y	○N
Excessive Thirst	○Y	○N
Excessive Bleeding	○Y	○N
Fainting/Dissiness	○Y	○N
Frequent Cough	○Y	○N
Frequent Diarrhea	○Y	○N
Frequent Headaches	○Y	○N
Genital Herpes	○Y	○N
Glaucoma	○Y	○N
Hay Fever	○Y	○N
Heart Attack/Failure	○Y	○N
Heart Murmur	○Y	○N
Heart Pace Maker	○Y	○N
Heart Trouble/Disease	○Y	○N
Hemophilia	○Y	○N
Hepatitis A	○Y	○N
Hepatitis B or C	○Y	○N
Herpes	○Y	○N
High Blood Press.	○Y	○N
Hives or Rash	○Y	○N
Hypoglycemia	○Y	○N
Irregular Heartbeat	○Y	○N
Kidney Problems	○Y	○N
Leukemia	○Y	○N
Liver Disease	○Y	○N
Low Blood Pressure	○Y	○N
Lung Disease	○Y	○N
Mitral Valve Prolapse	○Y	○N
Pain In Jaw Joints	○Y	○N
Parathyroid Disease	○Y	○N
Psychiatric Care	○Y	○N
Radiation Treatments	○Y	○N
Recent Weight Loss	○Y	○N
Renal Dialysis	○Y	○N
Rheumatic Fever	○Y	○N
Scarlet Fever	○Y	○N
Shingles	○Y	○N
Sickle Cell Disease	○Y	○N
Sinus Trouble	○Y	○N
Spina Bifida	○Y	○N
Stomach/Intestinal Disease	○Y	○N
Stroke	○Y	○N
Swelling of Limbs	○Y	○N
Thyroid Disease	○Y	○N
Tonsillitis	○Y	○N
Tuberculosis	○Y	○N
Tumors of Growth	○Y	○N
Ulcers	○Y	○N
Venereal Disease	○Y	○N
Yellow Jaundice	○Y	○N

Have you ever had any serious illness not listed above? ○Y ○N If yes, please explain: ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian: ______________________ Date: ____________



Dr. Keith Blessitt
Aesthetic Comprehensive Dentistry

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YOUR DENTAL HISTORY

Name and address of previous dentist: ______________________________
What is your immediate dental concern?:______________________________
Do you have or have you had?: Please circle: Yes or No.

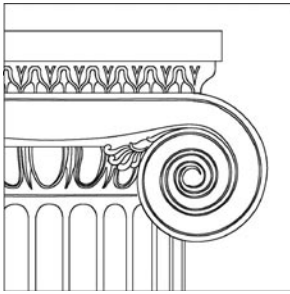
○Y ○N Problems with previous dental treatment or special concerns you would like to discuss?: ______________
____
○Y ○N Treatment by any dental specialist (e.g. Oral surgery, Orthodontics, Periodontist, Endodontist, Other) When and for what purpose?: ______________________________
○Y ○N Teeth whitening: when and what method?: ______________________________
○Y ○N Cosmetic dentistry: when, what procedure?: ______________________________
○Y ○N Dental pain: where, when or what causes the pain?: ______________________________
○Y ○N Gum disease, bleeding of gums, unpleasant taste or odor- where?: ______________________________
○Y ○N Growths, swellings, broken teeth in your mouth- where?: ______________________________
○Y ○N A bad reaction to dental anesthetics? Y N Nitrous Oxide or gas for dental treatment?: ______________
○Y ○N Do you have TMJ pain, headaches, jaw pain, jaw clicking, facial pain, clenching, grinding etc.?: __________
○Y ○N Do or did your parents or siblings have Gum disease, Dentures, Problems with cavities?: ______________
○Y ○N Other family history?: ______________________________

YOUR SMILE

Do you have? Please check all applicable numbers.

○ **1.** Not white, dark, dull, discolored or stained teeth.
○ **2.** Not straight, crooked teeth, out of line, overlapped, or a bad orthodontic result.
○ **3.** Spaces, gaps between your teeth.
○ **4.** Worn short teeth, teeth that are misshaped, too small or too large, pointed, or flat.
○ **5.** Poor result from dental veneers or crowns.
○ **6.** Old dental work, bondings, crowns, veneers that do not match your natural teeth.
○ **7.** Gums that are irregularly shaped, receded, or show too much when you smile.
○ **8.** Not centered, front teeth are not aligned with your face and nose.
○ **9.** Missing teeth.
○ **10.** Old dark mercury dental fillings.
○ **11.** Crowns with dark metal lines at the gum line.

Would you like to know how we can help improve your smile?: __________ Why?: ______________________



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DENTAL INSURANCE INFO

#1 Insurance Company (Primary Carrier) Ins. Co.: ______________________________ Phone#: ______________
Name of Insured: ______________________________ DOB: ________________ S,S.#: ____________________

#2 Insurance Company Ins. Co.: ______________________________ Phone#: ____________________________
Name of Insured: ________________________ Relationship to Insurance Holder: ____________________________

Payment Options
Cash, Check, Visa, Mastercard, American Express, Discover, Care Credit

Please note that insurance companies provide us with an estimate for services. Estimates given by insurance companies are not a guarentee of payment.

PLEASE READ SIGN AND DATE

Photography, video, images, and testimonials
A part of your diagnosis and care we routinely record images of your smile and other dental conditions. Some of these images mat be used for professional lectures, study, training and promotion. Will you please allow us to use your image by agreeing to the following? For value received, I consent and authorize Dr. Keith Blessitt to use my image and or testimonial letter, with or without my name, for dental health diagnosis, smile imaging, patient education, publication, research, promotion, professional lectures, or any other lawful purpose and I release and forever discharge him from any claim, demands or liability on account of such use or for the quality of the image reproduction or text.

Signature: ____ Date: ___________________________

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment.

I acknowledge that all information contained herein is true and correct and give my permission to verify any of the information provided. I the undersigned (patient or legally responsible party), have reviewed the HIPA Policy notice available for the office of Dr. Keith Blessitt.

Signature: ____ Date: ________________