THE Smile Gallery
THE ART OF FINE DENTISTRY

David J. Bainer, DDS

Patient Dental & Medical History Information

To our Patients: Please know that we may ask follow-up questions to make sure we have all the information we need in order to treat you

PATIENT INFORMATION

Last Name:	First Name:		Suffix:
Home Number:	Cell Phone:		
Email Address:			
Mailing Address:	City:	State:	Zip Code:
Date of Birth:	Gender:		

If you are completing this form for another person, what is your name and relationship to that person?
Name: _____ **Relationship:** _____

If you are completing this form as the patient's representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort?

When was your last dental exam? What was done at that appointment?

When was the last time you had dental x-rays taken?

WOMEN ONLY

Are you taking birth control? YES NO Are you pregnant? YES NO
Are you nursing? YES NO

Allergies, please use an "X" to mark ONLY the ones that apply to you

☐Aspirin ☐Metal ☐Penicillin ☐Latex ☐Codeine ☐Sulfa Drugs ☐Acrylic

☐Local anesthetics

Other: