Steven H. Brooksher, D.D.S.
Cosmetic and General Dentistry

Self-Assessment Form

The design of this worksheet is to help you begin to explore the priorities you would like us to consider during your first meeting with us. This form will become part of your permanent records.

What is most important for you to accomplish during your first visit?

What concerns do you have about your dental health?

What do you desire for your dental health and the appearance of your teeth?

What dental experiences do you hope not to have repeated?

Steven H. Brooksher, D.D.S.

General and Cosmetic Dentistry

Patient Information

Name____ Today's Date __________________

SS#_______-_____-___________ Date of Birth ____ /____ /____

Address________________________________ City______________ State___ Zip ______

Home Phone (____)________________ Work Phone (____)________________ Ext_____

Cellular (___)_________________ Drivers License Number________________

E-Mail Address ____

Please Circle: Male/Female Single/Married/Divorced/Widowed Full Time Student

Employer______________________________________ Occupation__________________

Emergency Contact ___________________________ Relationship____________________

Emergency Contact's Telephone # (___)___________________

Whom may we thank for referring you? ____

Responsible Party Information *(only if patient under 18 years old)*

Name ____ Relationship ___________________

Address________________________________ City______________ State___ Zip ______

SS#_______-_____-_________________ Date of Birth ____ /____ /____

Home Phone (____)________________ Work Phone (____)________________ Ext_____

Cellular (___)_________________

Dental Insurance Information

Subscriber's Name ____

Subscriber's Address ____

SS#____ DOB ________/________/_________

Employer Name ____

Insurance Company Name ___________________________ Group#_________________

Insurance Company Address ____

City _______________________ State _____Zip________ Phone ______________________

"Have you felt the attraction of a beautiful smile?"

Dental History (*please check yes or no*)

Yes No

- ☐ ☐ Have you ever had orthodontic treatment (braces)?
- ☐ ☐ Have you ever bleached your teeth?
- ☐ ☐ Have any of your teeth been removed? ☐ Wisdom teeth ☐ Other Teeth
- ☐ ☐ Have you had dental surgery (other than wisdom teeth)?
- ☐ ☐ Have you ever been told that you have gum disease?
- ☐ ☐ If yes, have you had Periodontal Treatment?
- ☐ ☐ Do you wear a removable prosthesis (complete or partial denture) to replace missing teeth?
- ☐ ☐ Do you wear or have you worn a splint/bite appliance?
- ☐ ☐ Have you ever experienced discomfort or noise in either of your jaw joints?
- ☐ ☐ Have you ever been aware of or has it been suggested that you grind your teeth?

Medical History

Primary care physician ______________________________

Have you been under the care of a doctor within the past 2 years? Yes/No

Have you been a patient in the hospital or emergency room within the last 2 years? Yes/No

Allergies to Medication and/or Other allergies______________________________

____

List all medications you are taking ______________________________

____

____

What other drugs or medications have you taken within the past 2 years?

____

Ladies: if pregnant? Yes/No Due Date__________ Nursing Yes/No Oral Contraceptive Yes/No

(please circle if you have or have had any of the following)

Prosthetic Heart Valve	Stroke	Asthma	Migraines
Congenital Heart Defect	Tumor	Colitis/Crohn's Disease	Glaucoma
Angina	Cancer	Anxiety Disorder	Hemophilia
Heart Murmur	Radiation Therapy	Clinical Depression	Excessive Bleeding
Dysrythmia	Chemotherapy	ADHD	Sickle Cell Anemia
Heart Attack	Diabetes I/II	ADD	STD
Heart Failure	Thyroid Disease	Alcohol/Drug Abuse	HIV+ / AIDS
Infective Endocarditis	Kidney Disease	Osteoporosis	Herpes/ Cold Sores
Pacemaker	Liver Disease	Prosthetic Joint	Seizures
Heart Surgery	Hepatitis	Arthritis	Epilepsy
High Blood Pressure	Tuberculosis	Headaches	Do you smoke or use smokeless tobacco?

Please elaborate on any of the above circled **OR** any other conditions not listed:

____

____

I, the patient/guardian, attest to the accuracy of the personal, dental, and medical information on both sides of this form

______________________________ (Patient/Guardian Signature)

__________ (Date)