

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?



“Have you felt the attraction of a beautiful smile?”

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 |
| Dysrhythmia | 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)