



BRIAN F. SCAFF, DDS
D E N T A L T E A M

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Call Today! (512) 258-9130

Visit Us Online: www.Scaff.com

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. **Please fill out this form as completely as possible.** We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

Spouse's Name: _____

Spouse's Birthdate: _____ SS#: _____

Spouse's Employer: _____ Occupation: _____

When and where are the best times to reach you? _____

Other Family Members Seen by Us: _____

DENTAL INSURANCE

If you have dental insurance, please give us that information on page 3!

EMERGENCY CONTACT (Please specify below whether your emergency contact lives in your household)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Does your emergency contact live in your household? **Yes** **No**

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature: _____

Date: _____

I understand that I will be required to pay my **estimated** portion of Dr. Brian Scaff's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature: _____

Date: _____

MEDICAL HISTORY

Do you have a physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently under the care/supervision of a physician? **Yes** **No** Please Explain: _____

Are you currently taking any prescription medications? **Yes** **No** Please List Medications with Correlating Diagnosis: _____

For Women: Are you currently taking any oral contraceptives (birth control pills)? **Yes** **No** Are you pregnant? **Yes** **No** Are you nursing? **Yes** **No**

Do you or have you ever used tobacco in any form? **Yes** **No** If yes, how much? _____ For how long? _____

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin • Barbiturates/Sleeping Pills • Codeine • Dental Anesthetics • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • Penicillin • Tetracycline • Vicodin

Please List Any Other Medications And/or Materials To Which You Think You Are Allergic: _____



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MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? Circle "Yes" or "No."

Abnormal Bleeding	Yes	No	Frequent Headaches	Yes	No	Psychiatric Problems	Yes	No
Alcohol or Drug Abuse	Yes	No	Heart Attack	Yes	No	Radiation Treatment	Yes	No
Arthritis	Yes	No	Heart Murmur	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Artificial Bones/Joints/Valves	Yes	No	Heart Surgery	Yes	No	Seizures	Yes	No
Cancer/Chemotherapy	Yes	No	Hemophilia	Yes	No	Sinus Problems	Yes	No
Congenital Heart Disease	Yes	No	Hepatitis	Yes	No	Sleep Apnea	Yes	No
Daytime Sleepiness	Yes	No	Herpes/Fever Blisters	Yes	No	Sleep Disorder	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No	Snoring	Yes	No
Difficulty Breathing	Yes	No	HIV or AIDS	Yes	No	Stroke	Yes	No
Emphysema	Yes	No	Kidney or Liver Disease	Yes	No	Thyroid Problems	Yes	No
Epilepsy	Yes	No	Low Blood Pressure	Yes	No	Ulcers	Yes	No
Fainting Spells	Yes	No	Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No
Fatigue	Yes	No	Pacemaker	Yes	No			

Please explain any serious medical conditions you have ever had: _____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? **Yes No** If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? **Yes No**

Do you have, or have you ever had any of the following conditions, ailments, or treatments? Circle "Yes" or "No."

Bad Breath	Yes	No	Food Collection Between Teeth	Yes	No	Orthodontic Treatment	Yes	No
Bleeding Gums	Yes	No	Foreign Objects in Mouth	Yes	No	Pain Around Ear	Yes	No
Blisters on Lips or in Mouth	Yes	No	Grinding Teeth	Yes	No	Pain When Brushing	Yes	No
Broken Fillings	Yes	No	Gums Swollen or Tender	Yes	No	Periodontal Treatment	Yes	No
Burning Sensation on Tongue	Yes	No	Jaw Pain	Yes	No	Sensitivity to Cold	Yes	No
Chew on Only One Side	Yes	No	Jaw Fatigue	Yes	No	Sensitivity to Heat	Yes	No
Clenching of Teeth	Yes	No	Lip or Cheek Biting	Yes	No	Sensitivity to Sweets	Yes	No
Clicking or Popping of Jaw	Yes	No	Loose Teeth	Yes	No	Sensitivity When Chewing	Yes	No
Dry Mouth	Yes	No	Mouth Breathing	Yes	No	Sores or Growths in Mouth	Yes	No

Have you ever had a serious/difficult problem associated with any previous dental work? **Yes No** Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes No**

How would you classify your current dental health? **Excellent Good Fair Poor Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? **Yes No** Would you like fresher breath? **Yes No** What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? **Yes No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____ What type of bristles does your toothbrush have? **Soft Medium Hard**

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Person Responsible for Account (If other than yourself):

Do you have Dental Insurance coverage? **Yes** **No**

Dental Insurance Co. Name _____

Dental Insurance Co. Address _____

City _____ State _____ Zip _____

Dental Insurance Co. Phone # _____

Group # _____

Insured's Name _____ Relationship _____

Insured's Birthday _____ SS# _____

Alternate ID# _____

Insured's Employer _____

Good Contact # of Insured _____

***Do you have secondary dental insurance coverage? Yes No**

Secondary Dental Insurance Co. Name _____

Secondary Dental Insurance Co. Address _____

City _____ State _____ Zip _____

Dental Insurance Co. Phone # _____

Group # _____

Insured's Name _____ Relationship _____

Insured's Birthday _____ SS# _____

Alternate ID# _____

Insured's Employer _____

Good Contact # of Insured _____

****If possible, please bring your dental insurance card(s) or,
insurance information for our records.***