WELCOME TO OUR OFFICE

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form.

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient Is (check all that apply): ☐ Policy Holder ☐ Responsible Party

Patient Information

Address: _____

City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Social Security # : _____ Driver's license #: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Referred By: _____ Previous Dentist: _____

Emergency Contact: _____ Emergency Contact #: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Social Security # : _____ Driver's license #: _____

Responsible Party is also a Policy Holder for Patient: ☐ Yes ☐ No

For office use only ID: _____ Chart ID: _____

Primary Insurance Information

Name of Insured: _____ Insured Birth Date: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder ID/Member ID Number: _____

Group Number: _____

Employer: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Insured Birth Date: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder ID/Member ID Number: _____

Group Number: _____

Employer: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Scott M. Smith D.D.S.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

Patient name: _____ Date of birth: _____

Are you under a physician's care now? ..... ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ..... ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ..... ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medication, pills or drugs? ..... ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ..... ☐ Yes ☐ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____
Do you use tobacco? ..... ☐ Yes ☐ No

Women– Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Angina ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No
Cold Sores/Fever Blister ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No
Cortisone Medicine ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Drug Addiction ☐ Yes ☐ No
Easily Winded ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Epilepsy or Seizures ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No
Fainting Spells/Dizziness ☐ Yes ☐ No
Heart Attack/Failure ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart Pacemaker ☐ Yes ☐ No
Heart Trouble/Disease ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Hepatitis A ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Hives or Rash ☐ Yes ☐ No
Hypoglycemia ☐ Yes ☐ No
Irregular Heartbeat ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Lung Disease ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pain in Jaw Joints ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No
Radiation Treatment ☐ Yes ☐ No
Renal Dialysis ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Rheumatism ☐ Yes ☐ No
Scarlet Fever ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Stomach/Intestinal Disease ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumors or Growths ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No
Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Dental History

Have you ever had an unfavorable reaction from a local anesthetic ☐ Yes ☐ No
Are you having pain or discomfort at this time? ..... ☐ Yes ☐ No
Reason for this visit: _____
How long since your last full-mouth X-Rays? _____
What was your last dental treatment for? _____

Do your gums bleed easily? ..... ☐ Yes ☐ No
Are you satisfied with the appearance of your teeth? ..... ☐ Yes ☐ No
If no, what would you change? _____
Have you ever: ☐ Worn Dentures ☐ Worn Partial Dentures
☐ Had Orthodontic Care or (Braces) ☐ Had Periodontal Treatment (Gums)
☐ Been treated for TMJ (Jaw Joint)

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. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the Dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents including finance charges for any unpaid account over 90 days past due, any fees charged by a collection agency, any attorney's fees and/or any other related charges.

Signature of Patient, Parent, or Guardian: _____ Date: _____