Dental Smiles

Name: _____ Date: _____

Social Security #: _____ Home Phone: _____

Birth date: _____ Cell Phone: _____

Residence Address: _____

City: _____ State/ Zip: _____

Employed By: _____ Business Phone/EXT: _____

Address of Employment: _____

Name of Spouse: _____ Birth Date: _____

Spouse's Social Security #: _____ Spouse Employed By: _____

Whom May We Thank For Referring You? _____

Who is Financially Responsible for This Account? _____

FINANCIAL AGREEMENTS:

I hereby choose one of the following methods of payment for my dental care and the care of any immediate family members.

1. I have no dental insurance.

_____ I elect to pay cash _____, check _____, or credit card _____ on all visits as treatment progresses.

_____ On extensive treatment, financial arrangements can be established.

2. I have dental insurance.

_____ I elect to pay on all visits as stated in above and will have my insurance company reimburse me.

_____ On extensive treatment, I elect to participate in financial arrangements coordinating insurance coverage and out-of-pocket expenses.

Your Dental Insurance Company: _____ Tel #: _____

Insurance Address: _____

Group/ Employer: _____ Group #: _____

Spouse's Dental Insurance Company: _____ Tel #: _____

Insurance Address: _____

Group/ Employer: _____ Group # _____

Authorization to release information: _____

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

I hereby agree to pay finance charges on any balance over 60 days. I hereby authorize the office of Dental Smiles to run a credit report if necessary.

_____ _____

Patient or Authorized Guardian Signature Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

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 medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ 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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

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

Comments: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

NEW PATIENT DENTAL HISTORY

How can we help you?_____

When was your last Dental visit? _____Were x-rays taken_____

Was there any dental treatment recommended that was not completed?_____

How often did you visit the Dentist in the past?_____

Previous Dentist name, address, tel# _____

How often do you brush your teeth?_____Floss your teeth?_____

Are you now in any dental discomfort?_____

Have you had any prior dental experiences that have been unpleasant?_____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?			ARE YOU HAVING ANY PROBLEMS WITH SNORING?		
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS OR SWEETS?			HAVE YOU EVER HAD PERIODONTAL TREATMENT? (GUMS)		
ARE YOU AWARE OF ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?			HAS THERE BEEN ANY LOSSENING OF YOUR TEETH?		
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?			DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?		
HAVE YOU HAD ANY HEAD NECK OR JAW INJURIES			HAVE YOU HAD ORTHODONTIC TREATMENT/ BRACES?		
DO YOU CLENCH OR GRIND YOUR TEETH?			EVER WORN A BITE PLATE OR OTHER APPLIANCE		
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?		
Clicking or popping while chewing? Pain (Joint, ear, side of face)?			DO YOU WEAR DENTURES OR PARTIALS? IF YES, DATE OF PLACEMENT_____		
Difficulty in chewing? Difficulty in opening or closing?			HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?		
DO YOU HAVE FREQUENT HEADACHES?			DO YOU LIKE YOUR SMILE?		

If you could change anything about your SMILE, what would that be?

_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED.

I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

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.

SIGNATURE OF PATIENT OR PARENT IF MINOR_____ DATE _____

DOCTOR'S COMMENTS

_____

_____

SIGNATURE _____ DATE_____