Welcome to Simply Sensational! Aesthetic Dentistry

Patient information (confidential)

Name_____ SS# ___ - __ - ____ Birth date __ / __ / ____

Address_____ City_____ State_____ Zip_____

Home Phone ___ - ___ - ____ Work Phone ___ - ___ - ____ ext ____ Cell/Pager ___ - ___ - ____

E-mail Adress_____

Patient's employer_____ Occupation_____

Single __ Married ___ Divorced __ Widowed __ Spouses Name_____

Who may we thank for referring you? _____

Responsible Party

Name of person responsible for account_____ Relation to patient_____

Address_____ City_____ State_____ Zip_____

SS# ___ - __ - ____ Birth date __ / __ / ____ Employer_____

Insurance Information

Name of insured_____ Relation to patient_____

SS# ___ - __ - ____ Birth date __ / __ / ____ Employer _____

Insurance Company _____ Group #_____

Insurance Company Address _____

Deductible amount _____ Max. Annual Benefit _____ Amount used _____

Additional Insurance Information

Do you have any additional dental insurance? Yes ___ No ____ If yes please provide following information

Name of insured_____ Relation to patient_____

SS# ___ - __ - ____ Birth date __ / __ / ____ Employer _____

Insurance Company _____ Group #_____

Insurance Company Address _____

Deductible amount _____ Max. Annual Benefit _____ Amount used _____

Patient Dental History

Name of previous dentist _____ Date of last exam _____ May we request records and/or x-rays? Y / N

Do your gums bleed while brushing/flossing?	Y / N	Do you clench or grind?	Y / N
Are your teeth sensitive to hot or cold?	Y / N	Have you had any orthodontic treatment?	Y / N
Do you wear dentures or partials?	Y / N	Have you had any difficult extractions?	Y / N
Do you have any sores or lumps in your mouth?	Y / N	Do you have any dental implants?	Y / N
Do you snore?	Y / N	Do you or have you ever smoked?	Y / N
Have you ever had prolonged bleeding after an extraction?	Y / N	Have you ever received oral hygiene instruction on care of your teeth and gums?	Y / N

Have you ever experienced any of the following? (Please circle if yes)

Clicking - Pain in joint, ear, or side of face - Difficulty in opening or closing mouth - Difficulty in chewing

Would you be interested in whitening your teeth or other ways to improve your smile?_____

Patient Medical History

Physician _____ Office Phone ___-___-____ Date of last exam _____

Do you currently have or have you ever been diagnosed with any of the following?

Mitro-Valve Prolapse	Y / N	Heart murmur	Y / N	Heart disease	Y / N
Joint replacement	Y / N	Blood disease	Y / N	Kidney disease	Y / N
Cosmetic Implants	Y / N	Diabetes	Y / N	Epilepsy	Y / N
Rheumatic Fever	Y / N	Arthritis	Y / N	Asthma	Y / N
Venereal Disease	Y / N	Leukemia	Y / N	Angina	Y / N
Thyroid Problem	Y / N	Emphysema	Y / N	Stroke	Y / N
Hepatitis/Jaundice	Y / N	Seizures	Y / N	Anemia	Y / N
Severe Headaches	Y / N	Pacemaker	Y / N	Cancer	Y / N
High Blood Pressure	Y / N	Chest Pains	Y / N	Ulcers	Y / N
Low blood Pressure	Y / N	Fever Blisters	Y / N	HIV/AIDS	Y / N
Tumor History	Y / N	Drug/Alcohol Abuse	Y / N	TB	Y / N
Heart Attack	Y / N	Osteoporosis	Y / N	Osteopenia	Y / N

Are you pregnant or think you may be pregnant? Y / N Nursing? Y/ N Taking Oral Contraceptives? Y / N

Are you allergic to or have you had an allergic reaction to any of the following
(Please circle if yes)

Local Anesthetics Penicillin/other antibiotics Sedatives
Barbiturates Latex Any Metals
Other (please list)_____

Are you taking or have you ever taken any of the following?

Fosamax (Alendronate)	Actonel (Residrenate)	Boniva (Ibandronate)
Aredia (Pamidronate)	Reclast (Zoledronic Acid)	Zometa (Zometa)

Please list other medications you are taking:_____

_____

Authorization and Release

The above medical history is complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination to third party payors and/or health practitioners.
I understand that my dental carrier may pay less than the actual bill for services, and I agree to be responsible for payment of all services rendered on my behalf or my dependents.
I acknowledge having received a copy of Trusted Dental Care notice of patient privacy practices.

Date_____Signature_____Relationship to Patient_____