PATIENT INFORMATION

E-mail_____Today's Date_____
Patient Name_____
☐ Married ☐ Single/Divorced ☐ Partnered ☐ Child/Minor
If patient is a minor, please list parent's or guardian's name _____
Address_____City_____State_____Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Birthdate_____ Social Security Number_____
Employer_____Occupation_____

Spouse Name_____Spouse Birthdate_____
Spouse Social Security Number_____Spouse Employer_____
Spouse Occupation_____

How did you learn about our office? _____
If you were referred by someone, whom may we thank? _____

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION

Responsible Party Name_____ Relationship to Patient_____
(Please fill out if information is different from above)
Address_____City_____State_____Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Birthdate_____ Social Security Number_____
Employer_____Occupation_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Birthdate_____ ID#/SS#_____
Insurance Company_____Group #_____
Insurance Phone_____Address_____
State_____ Zip_____Are you covered by 2 dental plans? _____
Do you have medical insurance besides Medicare? _____

CONSENT FOR TREATMENT

I hereby authorize my insurance benefits to be paid directly to Dr. Lori Smith.
I authorize release of any information relating to this dental claim. I realize that I am ultimately responsible for all costs of dental treatment.

Signature (patient or parent for minor)_____Date_____

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time, financial arrangements will be made before treatment is rendered. I hereby authorize Dr. Lori Smith to administer any treatment and to perform such x-rays, anesthetics and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

Signature (patient or parent for minor)_____Date_____

MEDICAL HISTORY

Who is your primary care physician? _____Physician's Phone Number_____
When was your last physical? _____How would you rate your overall health? _____
Have you been hospitalized in the last 2 years? _____If so why? _____

Are you currently taking any MEDICATIONS? Yes/No If so, please list all medications:_____
_____
_____

Are you ALLERGIC to any of the following medications/substances?

☐ Aspirin	☐ Iodine	☐ Novocaine	☐ Tetracycline
☐ Codeine	☐ Latex	☐ Penicillin/Amoxicillin	☐ Valium
☐ Erythromycin	☐ NSAIDS	☐ Sulfa Drugs	☐ Xylocaine

Do you have any other Allergies (food, drug, etc) :_____

Have you ever had any of the following? (**please check all that apply**)

☐ Allergies / Sinus Trouble	☐ Epilepsy or Seizures	☐ Low Blood Sugar
☐ ADHD	☐ Fever Blisters/Cold Sores	☐ Lung Disease/Respiratory Problems
☐ Arthritis or Gout	☐ Fibromyalgia	☐ Psychiatric Care/Depression
☐ Artificial Joint (Year_____)	☐ Glaucoma	☐ Radiation Treatment/ Chemotherapy
☐ Asthma (Inhaler? Yes / No)	☐ HIV-AIDS-ARC	☐ Rheumatic Fever/Scarlet Fever
☐ Autism	☐ Heart Attack/Heart Problems	☐ Severe Reaction to Laughing Gas or Anesthesia
☐ Bleeding Problem or Anemia	☐ Heart Murmur	☐ Sleep Apnea/ CPAP
☐ Blood Disease	☐ Heart Valve, Pacemaker, or Defibrillator	☐ Stroke (Year? _____)
☐ Bruise Easily	☐ Hepatitis A	☐ Thyroid Problems
☐ Cancer	☐ Hepatitis B	☐ Tuberculosis
☐ Congenital Heart Problems	☐ Hepatitis C	☐ Tumor Or Growth
☐ Currently Pregnant	☐ Herpes/Fever Blister	☐ Ulcers Or G.I. Problems/ Reflux
☐ Diabetes	☐ High Blood Pressure	☐ Do You Use Tobacco? _____
☐ Dizziness or Fainting	☐ Head Injury	☐ Cigarettes -Packs Per Day?_____
☐ Drug or Alcohol Addiction	☐ Jaw or TMJ Pain	
☐ Dry Mouth	☐ Kidney Disease/Dialysis	☐ Chewing/Smokeless Tobacco
☐ Eating Disorder	☐ Liver Disease	☐ Cigars
☐ Emphysema	☐ Low Blood Pressure	☐ Vaping

Do you have any conditions or problems not listed, which we should know about? If so, Please Explain: _____
_____

YES	NO	
☐	☐	Has a physician or previous dentist advised you to take antibiotics before dental treatment?
☐	☐	Have you ever taken medication for Osteoporosis OR prevention of Osteoporosis (Boniva, Fosamax, Actonel, Zometa, Reclast, etc)? If so, did you take the medication Daily, Weekly, Monthly, or Yearly? (Please circle one)
☐	☐	Have you recently consumed alcohol?
☐	☐	Have you recently used recreational drugs? (Recreational drugs combined with local anesthesia may cause a life threatening emergency.)
☐	☐	Do you Snore?

Dental History

What is the reason for your dental visit today? _____
Are you currently experiencing pain/discomfort? ☐ YES ☐ NO
When was your last dental visit? _____When was your last dental cleaning? _____
Have you ever had a serious head/mouth/neck injury? If yes, please explain. _____
_____

Please answer the following questions regarding your dental health.

YES	NO	
☐	☐	Do you have current dental concerns? If so, please explain _____
☐	☐	Are you nervous about dental treatment?
☐	☐	Have you avoided regular dental care? If so, please explain_____
☐	☐	Do you feel or have you been told that you have gum disease?
☐	☐	Have you had gum treatments? If so, please explain_____
☐	☐	Do you frequently have bad breath? How often do you brush?_____Floss?_____
☐	☐	Are you happy with the appearance of your teeth?
☐	☐	Would you like your teeth to be whiter?
☐	☐	Do you smoke/use tobacco products?
☐	☐	Do you grind or clench your teeth?
☐	☐	Do you have a protective night guard?
☐	☐	Are your teeth temperature sensitive? Sensitive to cold?_____ Hot?_____
☐	☐	Do you experience frequent headaches?
☐	☐	Do you frequently drink sugary drinks?
☐	☐	Have you seen a Dentist in the last year?

Date of last dental exam:_____ Date of Last X-rays:_____
Name of previous dental office_____ Phone Number_____

What are your dental expectations?_____
Emergency Contact or Nearest Relative _____ Phone Number _____

Dr's Notes:

Date Reviewed_____

Staff Signature_____