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Smile Dental Care PC

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WELCOME TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date: _____ Soc.Sec.#: _____ Birthdate: _____

Name: _____ Home Phone#: _____
Last First Initial

Address: _____ Cell Phone#: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Sex: ☐ M ☐ F Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Work Phone#: _____

Best Contact Method (Please circle): Email Text Phone: WORK CELL HOME

How did you hear from us? _____

In case of emergency, who should we contact? _____ Phone#: _____

PRIMARY INSURANCE

Person Responsible for Account: _____
Last First Initial

Relationship to Patient: _____ Birthdate: _____ Soc. Sec.#: _____

Address: _____ Home Phone#: _____ Cell Phone #: _____

City: _____ State: _____ Zip: _____

Responsible Party Employed By: _____ Business Phone#: _____

Insurance Company: _____

Insurance Company Address _____

Subscriber ID#: _____ Group #: _____

SECONDARY INSURANCE

Person Responsible for Account: _____
Last First Initial

Relationship to Patient: _____ Birthdate: _____ Soc. Sec.#: _____

Home Phone#: _____ Cell Phone #: _____

Responsible Party Employed By: _____ Business Phone#: _____

Insurance Company: _____ Subscriber ID#: _____ Group#: _____

DENTAL HISTORY

Former Dentist: _____ Date of Last X-Rays: _____
City, State: _____ How often Do you Floss: _____
Date of Last Dental Visit: _____ How often Do you Brush: _____

Please Check ALL that apply:

Bad Breath	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Bleeding Gums	Orthodontic Treatment	Sensitivity when Biting
Blisters on lips or mouth	Pain around Ear	Frequent Headaches
Finger Nail Biting	Periodontal Treatment	Jaw, Head or Neck Injuries
Grinding Teeth	Sensitivity to Cold	Jaw Difficulty: Clicking and/or Pain.
Lip or Cheek Biting	Sensitivity to Heat	Tooth Pain

MEDICAL HISOTRY

Physician's Name: _____ Date of Last Visit: _____

	YES	NO
Are you currently under medical treatment?		
Have you ever had any serious illnesses or operations?		
Are you currently taking any medication?		
Please describe: _____		
_____		
Do you smoke?		
Do you use alcohol, cocaine, or other drugs?		
Do you wear Contact Lenses?		
(Women Only) Are you: Pregnant?		Nursing? Taking Birth Control?

Have you had any allergic reactions to the following:

	YES	NO
Local Anesthetics (e.g. Novocain)		
Penicillin or other Antibiotics		
Sulfa Drugs		
Barbiturates (sleeping pills)		
Sedatives		
Iodine		
Aspirin		
Other		

PLEASE CHECK ALL THAT APPLY:

AIDS	Emphysema	Pacemaker
Anemia	Epilepsy	Psychiatric Care
Arthritis, Rheumatism	Fainting or Dizziness	Radiation Treatment
Artificial Heart Valves	Glaucoma	Respiratory Disease
Artificial Joints	Headaches	Rheumatic Fever
Asthma	Heart Murmur	Scarlet Fever
Back Problems	Hepatitis-Type_____	Shortness of Breath
Bleeding abnormally	Herpes	Sinus Trouble
With extractions or surgery	High Blood Pressure	Skin Rash
Blood Disease	HIV Positive	Stroke
Cancer	Jaundice	Swelling of Feet/Ankles
Chemical Dependency	Jaw Pain	Swollen neck glandes
Chemotherapy	Latex Sensitivity	Thyroid Problems
Chronic Fatigue Syndrome	Kidney Disease	Tonsillitis
Circulatory Problems	Liver Disease	Tuberculosis
Congenital Heart Lesions	Low Blood Pressure	Tumor or Growth on head/neck
Cortisone Treatments	Mitral Valve Prolapse	Ulcer
Cough-persistent/bloody	Nervous Problems	Venereal Disease
Diabetes		

AUTHORIZATION

I hereby authorize payment directly to Smile Dental Care P.C. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and all services rendered on my behalf or my dependents. I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____ Date: _____