## Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Martin					Soc. Sec. #	
NameLast Name	First No	ame	Initial			
Address						
			Zip		Home Phone	
Cell Phone						
Sex I M I F Age B						
Patient Employed by						
Business Address						
Business Email						
Whom may we thank for referring you?						
Notify in case of emergency			_ Home Phone			
Cell Phone			_ Business Pho	ne		
Email		3				
		Prin	mary Insur	ance		
Person Responsible for Account						
	L	ast Name			First Name	Initial
Relation to Patient		Birthdate			Soc. Sec. #	
Address (if different from patient)						
City						
Cell Phone						
Person Responsible Employed by						
Business Address						
Business Email						
Insurance Company						
Insurance Email						
Contract #					Subscriber #	
Name of other dependents under this plan _						
		Addi	tional Insu	irance		
Is patient covered by additional insurance?	□ Yes □	No				
Subscriber Name		lation to Patient			Birthdate	
Address (if different from patient)				_Soc. Sec.	.#	
City		State	Zip		Home Phone	
Cell Phone					Email	
Subscriber Employed by						
Business Email						
Insurance Company						
Insurance Email						
Contract #					Subscriber #	
Name of other dependents under this plan						

**Patient Information** 

Please complete both sides.

## **Dental History**

What would you like us to do today?				Are you in dental discomfort today?							
Former Dentist		Address	,								
Dentist's Email											
Date of last dental care	of last dental care Date of last x-rays										
<ul> <li>Check ( ✓ ) yes or no if you have had</li> <li>Y □ N Bad breath</li> <li>Y □ N Bleeding gums</li> <li>Y □ N Clicking or popping jaw</li> <li>How often do you brush?</li></ul>	problems w Y N F Y N G Y N G Y N L of your teeth e reaction d	ith any of the following: bood collection between teeth rinding or clenching teeth bose teeth or broken fillings ? uring or in conjunction with	Y N Y N Y N Floss?	<ul> <li>Y □ N Periodontal treatment</li> <li>Y □ N Sensitivity to sweets</li> <li>Y □ N Sensitivity to cold</li> <li>Y □ N Sensitivity to hot</li> <li>Y □ N Sensitivity to hot</li> <li>Y □ N Sores or growths in mouth</li> <li>Floss?</li> </ul>							
Medical History											
Physician's name											
Date of last visit Have you had any serious illnesses or operations? 🖸 Y 📮 N											
If yes, describe											
Are you currently under physician care? 🗅 Y 🕞 N If yes, describe											
Have you ever had a blood transfusion?  Y  N If yes, give approximate dates											
Have you ever taken Fen-Phen/Redux? $\Box$ Y $\Box$ N											
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. 🗆 Y 🗔 N											
Women: Are you pregnant? $\Box$ Y $\Box$ N Nursing? $\Box$ Y $\Box$ N Taking birth control pills? $\Box$ Y $\Box$ N											
Check ( $\checkmark$ ) yes or no whether you have	0		1								
□ Y □ N AIDS/HIV Positive		Cough, persistent	□ Y □ N	law pain		Shingles					
□ Y □ N Anaphylaxis		Cough up blood		Kidney disease or		0					
□ Y □ N Anemia		Diabetes		malfunction							
🗆 Y 🗔 N Arthritis, Rheumatism		Epilepsy	Y N	Liver disease							
$\Box$ Y $\Box$ N Artificial heart valves	IY IN	Fainting	Y N	Material allergies		Stroke					
□ Y □ N Artificial joints		Food allergies		( <b>latex</b> , wool, metal, chemicals)		Surgical implant					
🗆 Y 🗔 N Asthma	□ Y □ N	Glaucoma		Mitral valve prolapse		Swelling of feet					
$\Box$ Y $\Box$ N Atopic (allergy prone)		Headaches		Nervous problems		or ankles					
$\Box$ Y $\Box$ N Back problems	Y N	Heart murmur		Pacemaker/	□ Y □ N	Thyroid disease or					
$\Box$ Y $\Box$ N Blood disease		Heart problems		Heart surgery		malfunction					
$\Box$ Y $\Box$ N Cancer	Describe		□ Y □ N	Psychiatric care		Tobacco habit					
$\Box$ Y $\Box$ N Chemical dependency		Hemophilia/ Abnormal bleeding	□ Y □ N	Rapid weight gain or loss		Tonsillitis					
$\Box$ Y $\Box$ N Chemotherapy		Herpes	Y N	Radiation treatment		Tuberculosis					
$\Box$ Y $\Box$ N Circulatory problems			🗆 Y 🗆 N	Respiratory disease		Ulcer/Colitis Venereal disease					
$\Box$ Y $\Box$ N Cortisone treatments		High blood pressure	□ Y □ N	Rheumatic/Scarlet fever		venerear uisease					
Is patient currently taking any medications? If yes, list all:			Does patient have drug allergies? If yes, list all:								

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_

\_\_\_ Date

Payment is due in full at time of treatment, unless prior arrangements have been approved.

©SmartPractice®. All rights reserved.