SMITH FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Name_____ **Birthdate**__/__/__ **Home Phone**_____
Email_____ **Cell Phone**_____
Address_____ **City**_____ **State**___ **Zip**_____
Patient or Parent's Employer_____ **Work Phone**_____
Business Address_____ **City**_____ **State**___ **Zip**_____
Spouse or Parent's Name_____ **Employer**_____ **Work Phone**_____
Name of School/College (if Student)_____ **City**_____ **State**___
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency_____ **Phone**_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ **Relation to Patient**_____
Birthdate__/__/__ **SS#**_____ **Employer**_____ **Work Phone**_____
Billing Address_____ **Home Phone**_____
Currently a Patient in Our Office? **Yes** **No**

INSURANCE INFORMATION

Name of Insured_____ **Relation to Patient**_____
Birthdate__/__/__ **SS#**_____ **Date Employed**_____
Employer_____ **Work Phone**_____
Employer Address_____ **City**_____ **State**___ **Zip**_____
Insurance Company_____ **Group#**_____
Is Patient Covered by Additional Insurance? **Yes** **No**
Secondary Insurance Company_____ **Group#**_____

DENTAL HISTORY

Reason for today's visit_____
Date of last dental visit__/__/__ **Date of last dental X-rays**__/__/__
How often do you brush? _____ **How often do you floss?** _____
Do your gums bleed while flossing and brushing? **Yes** **No**
Do you suffer from chronic bad breath? **Yes** **No**
Do you get sores on your lips or in your mouth? **Yes** **No**
Special Needs of the Patient_____

OVER

Physician's Name_____ **Date of Last Visit**__/__/__

Have you been hospitalized in the past five years? **Yes** **No** **Reason**_____

Have you ever received a blood transfusion? **Yes** **No** **Approximate Dates**_____

WOMEN: *Are You Pregnant?* **Yes** **No** *Nursing?* **Yes** **No** *Taking Birth Control Pills?* **Yes** **No**

Check ☑ if you have or have had any of the following:

- ☐ **Anemia**
- ☐ **Arthritis, Rheumatism**
- ☐ **Artificial Heart Valve**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Back Problems**
- ☐ **Bleeding Problems After Surgery or Dental Extractions**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Chemical Dependency**
- ☐ **Circulatory Problems**
- ☐ **Cortisone Treatments**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Headaches**
- ☐ **Heart Murmur**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **HIV/AIDS**
- ☐ **Jaw Pain**
- ☐ **Kidney Disease**
- ☐ **Latex Allergy**
- ☐ **Liver Disease**
- ☐ **Mitral Valve Prolapse**
- ☐ **Pacemaker**
- ☐ **Radiation Treatment**
- ☐ **Respiratory Disease**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Shortness of Breath**
- ☐ **Stroke**
- ☐ **Swelling of Feet and Ankles**
- ☐ **Thyroid Problems**
- ☐ **Tobacco Habit**
- ☐ **Tuberculosis**
- ☐ **Venereal Disease**

MEDICATIONS_____

_____

_____

_____

ALLERGIES_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I authorize the doctor 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. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent/guardian if minor Date

MEDICAL HISTORY UPDATE **DATE**__/__/__

Please list any health changes:_____

Please list any new medications:_____

Patient Signature _____ Doctor Signature _____

MEDICAL HISTORY UPDATE **DATE**__/__/__

Please list any health changes:_____

Please list any new medications:_____

Patient Signature _____ Doctor Signature _____

MEDICAL HISTORY UPDATE **DATE**__/__/__

Please list any health changes:_____

Please list any new medications:_____

Patient Signature Doctor Signature