



## PATIENT INFORMATION

Patient Name: Dr. Mr. Mrs. Ms. Miss \_\_\_\_\_

By what name do you prefer to be called? \_\_\_\_\_

Birthday: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different than above: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

May we e-mail you about: Appointments? Yes No Special Offers? Yes No Dental Information? Yes No

Name of Employer: \_\_\_\_\_

If full time student, name of school: \_\_\_\_\_

Name of person responsible for account: \_\_\_\_\_

Address/Phone (if different from above): \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Relative Not Living With You: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## INSURANCE INFORMATION

First Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

Second Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

(PLEASE COMPLETE THE BACK SIDE OF THIS FORM)

# MEDICAL AND DENTAL HISTORY

## MEDICAL

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_\_ Are you under the care of a physician now?  YES  NO  
If **yes**, please explain: \_\_\_\_\_  
Have you ever been hospitalized, and if so for what? \_\_\_\_\_

### CIRCLE any of the following conditions you have or have had in the past:

Heart Failure	Artificial Joints/Prosthesis	Fainting/Dizzy Spells	Hay Fever
Heart Disease or Attack	Anemia	Nervousness	Sinus Trouble
Chest Pain	Stroke	Depression	Allergies/Hives
High Blood Pressure	Kidney Trouble/Disease	Psychiatric Treatment	Diabetes
Heart Murmur	Hepatitis	Sickle Cell Disease	Thyroid Disease
Mitral Valve Prolapse	Liver Disease	Glaucoma	Arthritis
Rheumatic Fever	Yellow Jaundice	Chemotherapy	Cortisone Medicine
Heart Defects	Blood Transfusion	(Cancer/Leukemia)	Pain in Jaw Joints
Scarlet Fever	Drug Addiction	Venereal Disease	HIV Positive
Artificial Heart Valve	Hemophilia	Bruise Easily	AIDS
Heart Pacemaker	Fever Blisters	Emphysema	Loss of Appetite
Heart Surgery	Epilepsy or Seizures	Asthma	Loss of Sleep

### CIRCLE any of the following medications you are allergic to or that have caused reactions:

Aspirin	Local Anesthetic (Novocain)	Valium
Nitrous Oxide	Codeine	Penicillin / Erythromycin
Percodan	<b>LATEX</b>	Sulfa

List any other medications that you are knowingly allergic to or have had a bad reaction to: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

Are you currently, or have you ever taking the drug **Fen Phen**?  YES  NO

Are you currently **pregnant**, trying to get pregnant, or **nursing**? (PLEASE CIRCLE)  YES  NO

**Are you currently taking Birth Control Pills?**  YES  NO

Is there any other medical information not included above which you feel we should be informed about?  YES  NO

If **yes**, please explain: \_\_\_\_\_

## DENTAL

1. What prompted you to seek dental care at this time? \_\_\_\_\_
2. How long has it been since your last thorough dental examination? \_\_\_\_\_
3. When were your teeth last cleaned? \_\_\_\_\_ X-rayed? \_\_\_\_\_
4. Has the fear of discomfort kept you from regular dental visits? \_\_\_\_\_
5. Are you satisfied with your past dentistry? \_\_\_\_\_
6. Have you had any bad experiences in a dental office? \_\_\_\_\_
7. Are you troubled with bad breath? \_\_\_\_\_
8. Do your gums bleed easily, feel tender or irritated? \_\_\_\_\_
9. Are your teeth sensitive to hot, cold or sweets? \_\_\_\_\_
10. Do you often have sores or fever blisters in your mouth? \_\_\_\_\_
11. Are there areas in your mouth where food sticks or gets caught? \_\_\_\_\_
12. Are you self-conscious about the appearance of your teeth? \_\_\_\_\_
13. Do your jaws often feel tired or sore? \_\_\_\_\_ If yes, when do you notice this feeling? \_\_\_\_\_
14. Do you experience excessive headaches and/or pain in the neck, shoulders or back? \_\_\_\_\_
15. Do you experience clicking or popping noises when opening or closing your mouth, or when chewing food? \_\_\_\_\_
16. Are you aware of grinding or clenching your teeth? \_\_\_\_\_
17. Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_
18. **What, if anything, would you do to change the appearance of your teeth?** \_\_\_\_\_

## CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize All Smiles Dental Care and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize All Smiles Dental Care and/or their trained staff to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

\_\_\_\_\_  
Signature of Patient / Parent or Guardian

\_\_\_\_\_  
Dr. Signature

\_\_\_\_\_  
Date