The Smile Center

WELCOME

Thank you for selecting our dental healthcare team. We will strive to provide you with the best dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need any assistance please ask and we will be happy to help.

**PATIENT INFORMATION (CONFIDENTAL) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name** (first, last, MI)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DL#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like to receive appointment reminders via text?** Y N **Via Email?** Y N

**Circle one:** Minor Single Married Divorced Widowed Separated **Sex:** Male Female

**Patient or Parent’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse or Parent’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us?** Patient referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radio Website Phone Book Sign Other\_\_\_\_\_\_\_\_\_\_

**Person to contact in case of an emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_**

**Over Please**

**INSURANCE INFORMATION**

**Name of insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date employed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ins. Company address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE ADDITIONAL INSURANCE?** Yes No **IF YES COMPLETE THE FOLLOWING**

**Name of insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date employed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ins. Company address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONSIBLE PARTY**

**Name of person responsible for account\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is this person currently a patient in our office?** Yes No

Thank you

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also agree to be responsible for 100% of the collection costs and legal fees.

Signature of patient or responsible party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

**PATIENT DENTAL HISTORY**

1. Do your gums bleed while brushing or flossing? Yes No 8. Do you have frequent headaches? Yes No

2. Are your teeth sensitive to hot or cold liquids/foods? Yes No 9. Do you clench or grind your teeth? Yes No

3. Are your teeth sensitive to sweet/sour liquids/foods? Yes No 10. Do you bite your lips or cheeks? Yes No

4. Do you feel pain to any of your teeth? Yes No 11. Have you ever had difficult extractions in the past? Yes No

5. Do you have any sores/lumps in or near your mouth? Yes No 12. Have you ever had any orthodontic work? Yes No

6. Have you ever had any head, neck, or jaw injuries? Yes No 13. Have you ever had prolonged bleeding after an extraction? Yes No

7. Have you ever experienced any of the following: 14. Have you ever had proper instruction on brushing your teeth? Yes No

 a) clicking in your jaw Yes No 15. Have you ever had proper instruction on gum care? Yes No

 b) pain (jaw, joint, side of face Yes No 16. Date of last dental cleaning:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 c.) difficulty opening or closing Yes No 17. Date of last dental x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 d.) difficulty chewing Yes No 18. Do you know someone who snores? Yes No

**Do you have, or have you had any of the following? (please circle)**

AIDS/HIV Positive Y/N Chest Pains Y/N Frequent headaches Y/N Hypoglycemia Y/N Rheumatic fever Y/N

Alzheimer’s disease Y/N Cold sores/fever blisters Y/N Genital herpes Y/N Irregular heartbeat Y/N Rheumatism Y/N

Anaphylaxis Y/N Congenital heart disorder Y/N Glaucoma Y/N Kidney Problems Y/N Scarlet fever Y/N

Anemia Y/N Convulsions Y/N Hay fever Y/N Leukemia Y/N Shingles Y/N

Angina Y/N Cortisone medicine Y/N Heart attack/failure Y/N Liver disease Y/N Sickle cell disease Y/N

Arthritis/gout Y/N Diabetes Y/N Heart murmur Y/N Low blood pressure Y/N Sinus trouble Y/N

Artificial heart valve Y/N Drug addiction Y/N Heart pacemaker Y/N Lung disease Y/N Spina Bifida Y/N

Artificial joint Y/N Easily winded Y/N Heart trouble/disease Y/N Mitral Valve Prolapse Y/N Stomach/intestinal disease Y/N

Asthma Y/N Emphysema Y/N Hemophilia Y/N Osteoporosis Y/N Stroke Y/N

Blood Disease Y/N Epilepsy/seizures Y/N Hepatitis A Y/N Pain in jaw or joints Y/N Swelling of limbs Y/N

Blood Transfusion Y/N Excessive bleeding Y/N Hepatitis B or C Y/N Parathyroid disease Y/N Thyroid disease Y/N

Breathing problems Y/N Excessive Thirst Y/N Herpes Y/N Psychiatric care Y/N Tonsillitis Y/N

Bruise Easily Y/N Fainting spells/dizziness Y/N High blood pressure Y/N Radiation treatment Y/N Tuberculosis Y/N

Cancer Y/N Frequent cough Y/N High Cholesterol Y/N Recent weight loss Y/N Tumors or growths Y/N

Chemotherapy Y/N Frequent diarrhea Y/N Hives or Rash Y/N Renal Dialysis Y/N Ulcers Y/N

Yellow Jaundice Y/N Venereal disease Y/N Other (not listed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY**

**Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1 Are you under medical treatment now? Yes No 8. Are you allergic to or have had any reaction to the following:**

**2. Have you ever been hospitalized for any** Metal/Nickel Yes No

 **reason? Yes No** local anesthetics (Novocain ) Yes No

**3. Do you require antibiotic pre-medication? Yes No** Penicillin or other antibiotics Yes No

**4. Are you taking any medication including Yes No** Sulfa Drugs Yes No

 **Nonprescription medicine? (LIST)** Barbiturates Yes No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Sedatives Yes No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Iodine Yes No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Aspirin Yes No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Other (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Do you use tobacco? Yes No 9. Women only:**

**6. Do you use recreation drugs? Yes No**  a.) are you pregnant or could be pregnant? Yes No

**7. Are you wearing contact lenses? Yes No** b.) are you nursing? Yes No

c.) are you taking birth control? Yes No