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.

Patient Information

Name		ratterit	IIIIOIIII	111011	
Clast Name First Name Initial	Name			Soc. Sec. #	AND SECURITION
City State Zip Home Phone Cell Phone Email Single Married Widowed Separated Divorced Patient Employed by Occupation Business Address Business Address Business Fhone Business Famil Whom may we thank for referring you? Home Phone Cell Phone Business Phone Business Phone Business Phone Email Primary Insurance Person Responsible for Account Birthdate Soc. Sec. # Initial Address (if different from patient) Home Phone City State Zip Cell Phone Email Person Responsible Employed by Occupation Business Email Phone Group Final Suriance State Susiness Email Contract # Susiness Email Suriance Company Phone Business Email Contract # Subscriber Address (if different from patient) Patient Subscriber Mane Relation to Patient Subscriber Birthdate Subscriber Birthdate Subscriber Subscriber Subscriber Patient Subscriber Additional Insurance Subscriber Patient Subscriber Subscriber Patient Subscriber Subscriber Patient Subscriber Subscriber Subscriber Patient Subscriber Subscriber Subscriber Patient Subscriber Patient Subscriber Patient Subscriber Patient Subscriber Subscriber Patient Pati	Last Name	First Name	Initial		
Cell Phone Email Sex	Address				
Sex					
Patient Employed by					
Business Address					
Business Email Whom may we thank for referring you? Notify in case of emergency. Cell Phone Email Primary Insurance Person Responsible for Account Last Name First Name Initial Relation to Patient Address (if different from patient) Cell Phone Email Soc. Sec. # Home Phone City State Zip Cell Phone Email Person Responsible Employed by Occupation Business Phone Business Phone Business Phone Business Phone Additional Insurance Insurance Email Contract # Name of other dependents under this plan Additional Insurance Relation to Patient Birthdate Soc. Sec. # Address (if different from patient) Additional Insurance Birthdate Birthdate Soc. Sec. # Address (if different from patient) Soc. Sec. #	Patient Employed by			Occupation	
Whom may we thank for referring you? Notify in case of emergency					
Notify in case of emergency					
Cell Phone					
Person Responsible for Account Last Name Relation to Patient Roll different from patient) City State Cell Phone Person Responsible Employed by Business Address Business Phone Business Email Insurance Company Insurance Company Phone Group # Name of other dependents under this plan Additional Insurance Soc. Sec. # Insurance Additional Insurance Birthdate Soc. Sec. # Birthdate Birthdate Soc. Sec. # Birthdate Birthdate Soc. Sec. #					
Person Responsible for Account Last Name Birthdate Soc. Sec. # Address (if different from patient) City State Zip Cell Phone Email Person Responsible Employed by Business Address Business Phone Business Email Insurance Company Insurance Email Contract # Name of other dependents under this plan Additional Insurance Soc. Sec. # Home Phone Email Occupation Business Phone Business Phone Additional Insurance Subscriber # Name of other dependents under this plan Additional Insurance Birthdate Address (if different from patient) Soc. Sec. # Birthdate Birthdate Soc. Sec. #				lone	
Person Responsible for Account Last Name Relation to Patient Address (if different from patient) City State Zip Cell Phone Person Responsible Employed by Business Address Business Phone Business Email Insurance Company Insurance Email Contract # Name of other dependents under this plan Additional Insurance Is patient covered by additional insurance? Relation to Patient Soc. Sec. # Initial First Name Soc. Sec. # Initial First Name Initial First Name Soc. Sec. # Address (if different from patient) Soc. Sec. # Birthdate Soc. Sec. #	Email		DESCRIPTION OF THE PERSON NAMED IN		
Relation to Patient		Primar	y Insura	ince	
Relation to Patient	Person Responsible for Account				
Address (if different from patient) Home Phone		Last Name	3	First Name	Initial
City	Relation to Patient	Birthdate_		Soc. Sec. #	
Cell Phone	Address (if different from patient)		No.	Home Phone	
Person Responsible Employed by	City		State	Zip	
Business Address					
Business Email	Person Responsible Employed by			Occupation	
Insurance Company Phone	Business Address	over the latest the latest		Business Phone	
Insurance Company Phone	Business Email			Print Market State Co.	
Insurance Email Group # Subscriber # Name of other dependents under this plan Additional Insurance Is patient covered by additional insurance?					
Additional Insurance Is patient covered by additional insurance? Subscriber Name Address (if different from patient) Soc. Sec. #					
Additional Insurance Is patient covered by additional insurance? Subscriber Name Address (if different from patient) Soc. Sec. #					
Additional Insurance Is patient covered by additional insurance?					
Is patient covered by additional insurance?					
Subscriber Name Relation to Patient Birthdate Address (if different from patient) Soc. Sec. #		Addition	nal Insu	rance	
Address (if different from patient) Soc. Sec. #	Is patient covered by additional insurance?	☐ Yes ☐ No			
	Subscriber Name	Relation to	Patient	Birthdate	
	Address (if different from patient)				
City Home Phone			Zip	Home Phone	
Cell Phone Email					
Subscriber Employed by Business Phone					
Business Email					
Insurance Company Phone					
Insurance Email					
Contract # Group # Subscriber #					
Name of other dependents under this plan					
Please complete both sides.	Traine of other dependents under this plant		mnlete both	sides.	

Dental History ___ Are you in dental discomfort today? _ What would you like us to do today?_ Address Former Dentist Phone _ Dentist's Email ___ __ Date of last x-rays___ Date of last dental care _____ Check (✓) yes or no if you have had problems with any of the following: ☐ Y ☐ N Bad breath □ Y □ N Food collection between teeth □ Y □ N Periodontal treatment □ Y □ N Sensitivity to sweets ☐ Y ☐ N Bleeding gums □ Y □ N Grinding or clenching teeth □ Y □ N Sensitivity to cold □ Y □ N Sensitivity when biting □ Y □ N Clicking or popping jaw □ Y □ N Loose teeth or broken fillings □ Y □ N Sensitivity to hot ☐ Y ☐ N Sores or growths in mouth __ Floss?__ How often do you brush? _ How do you feel about the appearance of your teeth? Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □ Y □ N Other information about your dental health or previous treatment_ Medical History Physician's name _____ Phone _ Have you had any serious illnesses or operations? UY N Date of last visit _ If ves, describe ___ Are you currently under physician care?

Y

N

If yes, describe If yes, give approximate dates____ Have you ever had a blood transfusion? □ Y □ N Have you ever taken Fen-Phen/Redux? □Y □N Nursing? □Y □N Taking birth control pills? □Y □N Women: Are you pregnant? □Y □N Check (✓) yes or no whether you have had any of the following: ☐ Y ☐ N Jaw pain ☐ Y ☐ N Shingles ☐ Y ☐ N AIDS/HIV Positive ☐ Y ☐ N Cough, persistent ☐ Y ☐ N Shortness of breath ☐ Y ☐ N Kidney disease or ☐ Y ☐ N Anaphylaxis ☐ Y ☐ N Cough up blood malfunction ☐Y ☐ N Anemia ☐Y ☐ N Diabetes ☐ Y ☐ N Skin rash ☐ Y ☐ N Liver disease ☐ Y ☐ N Spina Bifida ☐ Y ☐ N Arthritis, Rheumatism ☐Y ☐N Epilepsy ☐ Y ☐ N Material allergies ☐Y ☐ N Stroke □ Y □ N Artificial heart valves ☐ Y ☐ N Fainting (latex, wool, metal, ☐ Y ☐ N Surgical implant ☐ Y ☐ N Artificial joints ☐ Y ☐ N Food allergies chemicals) ☐ Y ☐ N Swelling of feet ☐Y ☐ N Asthma ☐ Y ☐ N Glaucoma ☐ Y ☐ N Mitral valve prolapse or ankles □ Y □ N Atopic (allergy prone) ☐Y ☐ N Headaches ☐ Y ☐ N Nervous problems ☐ Y ☐ N Thyroid disease or ☐ Y ☐ N Back problems ☐Y ☐ N Heart murmur ☐Y ☐ N Pacemaker/ malfunction ☐ Y ☐ N Heart problems □ Y □ N Blood disease Heart surgery ☐ Y ☐ N Tobacco habit Describe ☐Y ☐N Cancer ☐ Y ☐ N Psychiatric care ☐ Y ☐ N Tonsillitis ☐Y ☐ N Hemophilia/ □ Y □ N Chemical dependency ☐ Y ☐ N Rapid weight gain or loss ☐ Y ☐ N Tuberculosis Abnormal bleeding ☐ Y ☐ N Chemotherapy □ Y □ N Radiation treatment ☐Y ☐ N Ulcer/Colitis ☐Y ☐ N Herpes ☐ Y ☐ N Circulatory problems ☐ Y ☐ N Respiratory disease ☐ Y ☐ N Venereal disease ☐ Y ☐ N Hepatitis □ Y □ N Cortisone treatments ☐ Y ☐ N Rheumatic/Scarlet fever ☐ Y ☐ N High blood pressure 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.

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

Signature

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