The Smile Designers

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Date _____ REFERRED BY _____

Patient Name _____ DATE OF BIRTH _____

Spouse's Name _____ DATE OF BIRTH _____

If Child, Parent's Name _____ DATE OF BIRTH _____

Residence - Street _____ RESIDENCE PHONE _____

City/State/Zip _____ E-MAIL _____

Cell Phone _____ BUSINESS PHONE _____

Employer _____ SPOUSE'S EMPLOYER _____

Patient's or Guardian SS# _____ SPOUSE'S SS #` _____

Primary Dental Insurance and Group # _____

Secondary Dental Insurance and Group # _____

In Case of Emergency: Name _____ Phone _____

Yes No

☐ ☐ College Student _____

PATIENT MEDICAL HISTORY

Last (Medical) Exam _____

Physician (General) _____ Phone _____

Physician (Specialist) _____ Phone _____

PHARMACY _____ Phone _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma? Respiratory Disease?	☐	☐	Heart Problem?	☐	☐	Kidney Disease?
☐	☐	Arthritis or Rheumatism?	☐	☐	Hepatitus and/or Jaundice?	☐	☐	Latex Allergy?
☐	☐	Blood Disease?	☐	☐	High Blood Pressure?	☐	☐	Liver Disease?
☐	☐	Diabetes?	☐	☐	HIV+?	☐	☐	Mitral Valve Prolapse?
☐	☐	Fainting?	☐	☐	Intestinal or Stomach Disease?	☐	☐	Pacemaker?
☐	☐	Growths or Tumors?	☐	☐	Joint Replacement?	☐	☐	Venereal Disease?
☐	☐	Heart Murmur - Adult	☐	☐	Heart Murmur - Child	☐	☐	Rheumatic Fever?

Yes No

☐ ☐ Are you under any medical treatment? If yes, please specify _____

_____

☐ ☐ Are you taking any medications now? If yes, please specify _____

_____

☐ ☐ Have you ever had a head injury? Concussion? If yes, please specify _____

_____

☐ ☐ Have you had any allergic reaction to any medicines? If yes, please specify _____

_____

please turn over

Continued from Front

Yes No

- ☐ ☐ Are you on any recreational drugs, such as cocaine, etc.? ***Dangerous* when used with local anesthetic!**
- ☐ ☐ Do you have night sweats followed by weight loss/cough?
- ☐ ☐ Are you on a diet at this time? If yes, is it doctor supervised? ☐ *Yes* ☐ *No*
- ☐ ☐ Are you allergic to any known materials? resulting in hives, asthma, eczema, etc.?
- ☐ ☐ Have cuts healed slowly or presented other complications?
- ☐ ☐ Have you ever had any radiation treatments? Chemotherapy?
- ☐ ☐ Allergy to metals?

FOR WOMEN ONLY

Yes No

- ☐ ☐ Please specify if you are or might be Pregnant
- ☐ ☐ Are you taking the Birth Control Pill?

DENTAL HEALTH HISTORY

Yes No

- ☐ ☐ Do your gums bleed?
- ☐ ☐ Do you have pain in your ears?
- ☐ ☐ Do you have any unhealed areas in your mouth?
- ☐ ☐ Have you had any growth or sore spots in your mouth?
- ☐ ☐ Does any part of your mouth hurt when clenched?
- ☐ ☐ Do you chew on one side of your mouth? If so, why?_____
- ☐ ☐ Do you have headaches?
- ☐ ☐ Do you habitually clench your teeth during the day or night?

NEW PATIENTS ONLY

Why did you leave your former dentist? _____

Yes No

- ☐ ☐ Are you satisfied with the appearance of your teeth? _____
- ☐ ☐ Do you have any dental complaints? _____
- ☐ ☐ When was your last dental exam and cleaning? _____
- ☐ ☐ Were any X-rays taken of your teeth? ☐ Bitewing: Date _____ ☐ Panorex: Date_____
- ☐ ☐ Do you wear a partial or denture? If yes, how long? _____

Have you ever had:

Yes No

- ☐ ☐ Novocaine anesthetic?
- ☐ ☐ Any allergic reaction to novocaine?
- ☐ ☐ Any difficult extractions?
- ☐ ☐ Prolonged bleeding following extractions?
- ☐ ☐ Trench Mouth?

I HAVE BEEN INFORMED OF THE TREATMENT PLAN AND ASSOCIATED FEES. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS, OTHERWISE PAYABLE TO ME, DIRECTLY TO THE SMILE DESIGNERS.

SIGNED (Responsible Party) ✘_____ DATE_____

I HAVE BEEN INFORMED OF THE OFFICE'S PRIVACY PRACTICES. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID FOR, BY PLAN BENEFITS, IF APPLICABLE. SHOULD THIS ACCOUNT GO TO COLLECTION, THE BELOW SIGNED PERSON AGREES TO PAY ALL COLLECTION AND ATTORNEY FEES.

SIGNED (Responsible Party) ✘_____ DATE_____