The Smile Designers

STEVEN B. GROSSMAN, D.D.S. & MARK E. WESTCOTT, D.M.D.

Date _____ **Referred by** _____

Patient Name _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip** _____

Insurance (Name) _____

Workplace _____

Your current phone numbers:

_____

Home | Work | Cell

Emergency Contact Name & 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?**	☐	☐	**Penicillin Allergy?**
☐	☐	**Diabetes?**	☐	☐	**HIV+?**	☐	☐	**Liver Disease?**
☐	☐	**Fainting?**	☐	☐	**Intestinal or Stomach Disease?**	☐	☐	**Mitral Valve Prolapse?**
☐	☐	**Growths or Tumors?**	☐	☐	**Joint Replacement?**	☐	☐	**Pacemaker?**
☐	☐	**Heart Murmur - Adult**	☐	☐	**Heart Murmur - Child**	☐	☐	**Venereal Disease?**
						☐	☐	**Rheumatic Fever?**

List all medications you are allergic to: _____

_____

List all medications you are currently taking: _____

_____

I agree to be responsible for all charges for the dental services and material not paid for by the plan benefit. If applicable, should this account go into collection, the below signed person agrees to pay all collection and attorney fees.

Signed (responsible party) ✗ _____