Date_____ GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	**SOCIAL SECURITY NUMBER**	**PHONE** ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	Driver's License and State
Email	I would like to receive emails from Smart Dental Care: ❑ Yes ❑ No	
Cell Phone	I would like to receive text reminders about my appointments: ❑ Yes ❑ No	
Primary Insurance Company	ID #	Subscriber
Secondary Insurance Company	ID #	Subscriber
Responsible Party		
NAME	SOCIAL SECURITY NUMBER	PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	Driver's License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Phone ( )
Spouse's Business Address	City	State Zip
In the event of an emergency, please contact: Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

How did you hear about our Office?

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find our Office? ❑ Referred by a Friend/Acquaintance ❑ Yellow Pages ❑ Internet Search ❑ Insurance Plan ❑ Social Media ❑ Newspaper Ad ❑ Direct Mailer ❑ Sign by Building

If you were referred, whom may we thank for referring you? _____

Consent

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out the procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

For the following questions, please mark (X) your responses

DENTAL INFORMATION

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	❑	❑	Do you have earaches or neck pains?	❑	❑
Are your teeth sensitive to cold, hot, sweets, or pressure?	❑	❑	Do you have any clicking, popping or discomfort in the jaw?	❑	❑
Does food or floss catch between your teeth?	❑	❑	Do you brux or grind your teeth?	❑	❑
Is your mouth dry?	❑	❑	Do you have sores or ulcers in your mouth?	❑	❑
Have you had any periodontal (gum) treatment?	❑	❑	Do you wear dentures or partials?	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	Do you participate in active recreational activities?	❑	❑
Is your home water supply fluoridated?	❑	❑	Have you ever had a serious injury to your head or mouth?	❑	❑
Are you currently experiencing dental pain or discomfort?	❑	❑			
Date of last dental visit?			Date of last dental x-rays:		
What was done at that time?					
How do you feel about your smile?					

MEDICAL INFORMATION

Physician Name:	Phone:
Address/City/State/Zip	

Has there been any change in your general health within the past year?
Please explain:_____
_____
_____

Are you taking or have you recently taken any prescription or over the counter medicines? ❑ Yes ❑ No

If so, please list all, including vitamins, herbal preparations, or supplements:_____
_____
_____

	Yes	No		Yes	No
Joint Replacement: Have you had an orthopedic total joint replacement? _____ Date:_____ Any complications:_____	❑	❑	Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	❑	❑
Do you use controlled substances (drugs)?	❑	❑	Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment Began:_____	❑	❑
Do you use tobacco? If so, are you interested in stopping? _____	❑	❑			
Do you drink alcoholic beverages?	❑	❑			

Allergies: Are you allergic to or have you had a reaction to: (List type of reaction)	Yes	No		Yes	No
Local anesthetics_____	❑	❑	Metals_____	❑	❑
Aspirin_____	❑	❑	Latex_____	❑	❑
Penicillin or other antibiotics_____	❑	❑	Iodine_____	❑	❑
Barbiturates, sedatives, or sleeping pills_____	❑	❑	Hay fever/seasonal_____	❑	❑
Sulfa drugs_____	❑	❑	Animals_____	❑	❑
Codeine or other narcotics_____	❑	❑	Food_____	❑	❑
	❑	❑	Other_____	❑	❑

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems

Artificial (prosthetic) heart valve	❑	❑							
Previous Infective endocarditis	❑	❑							
Damaged valves in transplanted heart	❑	❑							
Congenital Heart Disease (CHD)	❑	❑							
Cardiovascular disease	Yes ❑	No ❑	Mitral valve prolapse	Yes ❑	No ❑				
Angina	❑	❑	Pacemaker	❑	❑				
Arteriosclerosis	❑	❑	Rheumatic fever	❑	❑				

Women Only: Are you:

	Yes	No
Pregnant_____	❑	❑
Taking birth control pills_____	❑	❑
Nursing_____	❑	❑

	Yes	No		Yes	No
Autoimmune disease	❑	❑	Hepatitis, jaundice or liver disease	❑	❑
Rheumatoid arthritis	❑	❑	Epilepsy	❑	❑
Systemic lupus erythematosus	❑	❑	Fainting spells or seizures	❑	❑
Asthma	❑	❑	Neurological disorders	❑	❑
Bronchitis	❑	❑	Sleep disorder	❑	❑

(cont. on other side)

MEDICAL INFORMATION (cont.)

	Yes	No		Yes	No		Yes	No		Yes	No
Congestive heart failure	❑	❑	Rheumatic heart disease	❑	❑	Emphysema	❑	❑	Mental health disorder	❑	❑
Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Sinus trouble	❑	❑	Recurrent infections	❑	❑
Heart attack	❑	❑	Anemia	❑	❑	Tuberculosis	❑	❑	Kidney problems	❑	❑
Heart murmur	❑	❑	Severe headaches/ migraines	❑	❑	Cancer/Chemotherapy/ Radiation Treatment	❑	❑	Persistent swollen glands in neck	❑	❑
Low blood pressure	❑	❑	AIDS or HIV	❑	❑	Chronic pain	❑	❑	Osteoporosis	❑	❑
High blood pressure	❑	❑	Arthritis	❑	❑	Diabetes	❑	❑	Hemophilia	❑	❑
Eating disorder	❑	❑	Gastrointestinal disease	❑	❑	G.E. Reflux/Heartburn	❑	❑	Sexually transmitted disease	❑	❑
Thyroid problems	❑	❑	Stroke	❑	❑	Glaucoma	❑	❑	Ulcers	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment		Yes ❑ No ❑
Name of physician or dentist making recommendation:	Phone:	
Do you have any disease, condition, or problem not listed above that we should be aware of? Please explain:		❑ ❑
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.		
Signature of Patient/Legal Guardian:	Date:	