familysmiles

PATIENT FORM

WE ARE PLEASED TO WELCOME YOU TO OUR OFFICE.
PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN.
IF YOU HAVE ANY QUESTIONS WE WILL BE GLAD TO HELP YOU.

HOW DID YOU HEAR ABOUT US?:

(If someone referred you here, please write down their name so we can thank them)

PATIENT INFORMATION

PATIENT'S NAME: last first mi

BIRTHDATE: SOC. SEC #: GENDER: (M)☐ (F)☐ MARRIED: (Y)☐ (N)☐

WORK PHONE: CELL PHONE:

EMAIL ADDRESS:

PREFERRED CONTACT METHOD: (WORK PHONE) (CELL PHONE) (EMAIL)

ADDRESS AND HOME PHONE

CHECK BOX IF SAME FOR THE ENTIRE FAMILY: ( )

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE:

INSURANCE POLICY 1

RELATIONSHIP TO SUBSCRIBER: (SELF) (SPOUSE) (CHILD)

SUBSCRIBER NAME: SUBSCRIBER ID #:

DOB: INSURANCE COMPANY: PHONE:

EMPLOYER: GROUP #/ NAME:

INSURANCE POLICY 2

RELATIONSHIP TO SUBSCRIBER: (SELF) (SPOUSE) (CHILD)

SUBSCRIBER NAME: SUBSCRIBER ID #:

DOB: INSURANCE COMPANY: PHONE:

EMPLOYER: GROUP #/ NAME:

DENTAL HISTORY

WHAT IS THE REASON FOR YOUR VISIT TODAY?:

IF THIS IS AN EMERGENCY, PLEASE DESCRIBE:

FORMER/CURRENT DENTIST: DATE OF LAST DENTAL VISIT:

HOW OFTEN DOES THE PATIENT BRUSH?: FLOSS?:

DOES THE PATIENT EXPERIENCE PAIN OR DISCOMFORT IN THE JAW JOINT?: (Y)☐ (N)☐

HAS THE PATIENT EVER EXPERIENCED A MOUTH OR CHIN INJURY?: (Y)☐ (N)☐

DOES THE PATIENT HAVE SPEECH PROBLEMS?:

HAS THE PATIENT EVER EXPERIENCED ANY UNUSUAL REACTIONS TO DENTAL INJECTIONS?: (Y)☐ (N)☐

DO YOUR GUMS BLEED EASILY? (Y)☐ (N)☐

DO YOU GRIND YOUR TEETH? (Y)☐ (N)☐

OTHER INFORMATION ABOUT THE PATIENT'S PREVIOUS DENTAL TREATMENT:

MEDICAL HISTORY

PATIENT'S PHYSICIAN: PHONE:

DATE OF LAST VISIT: IS THE PATIENT CURRENTLY UNDER PHYSICIAN CARE?: (Y)☐ (N)☐

PLEASE LIST ANY MEDICAL CONDITIONS THE PATIENT MAY HAVE INCLUDING:

ASTHMA	☐(Y) ☐(N)	HEART MURMUR	☐(Y) ☐(N)	KIDNEY DISEASE	☐(Y) ☐(N)
BLEEDING PROBLEMS	☐(Y) ☐(N)	HEART TROUBLE	☐(Y) ☐(N)	LIVER DISEASE	☐(Y) ☐(N)
HIV	☐(Y) ☐(N)	HIGH BLOOD PRESSURE	☐(Y) ☐(N)	EPILEPSY	☐(Y) ☐(N)
HEADACHES	☐(Y) ☐(N)	RESPIRATORY DISEASE	☐(Y) ☐(N)	THYROID DISEASE	☐(Y) ☐(N)
CANCER	☐(Y) ☐(N)	ANEMIA	☐(Y) ☐(N)	PREGNANCY	☐(Y) ☐(N)
DIABETES	☐(Y) ☐(N)	JOINT REPLACEMENT	☐(Y) ☐(N)	PSYCHIATRIC TREATMENT	☐(Y) ☐(N)
SINUS TROUBLE	☐(Y) ☐(N)	STROKE	☐(Y) ☐(N)	ULCERS	☐(Y) ☐(N)
HISTORY OF RHEUMATIC FEVER	☐(Y) ☐(N)	MATERIAL ALLERGIES (LATEX)	☐(Y) ☐(N)	HEPATITIS	☐(Y) ☐(N)

(WOMEN) ARE YOU PREGNANT NOW? (Y)☐ (N)☐ IF YES , HOW MANY MONTHS? _____

ARE YOU NURSING? (Y)☐ (N)☐

ANY ADDITIONAL MEDICAL INFORMATION:

LIST ANY MEDICATIONS PATIENT IS TAKING:

LIST DRUG ALLERGIES, IF ANY:

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 the patient's medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay 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 the insurance company.

SIGNATURE: DATE: