**Patient Information**  *Adult/Child:* **\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_\_

Gender (Male/Female): \_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (Single/Married/Divorced/Widower): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt./Condo #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When and where are the best times to contact you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Options:**

Credit/ Debit Card Cash/ Check

Other

**How did you hear about us?**

Internet Facebook Flyer/Mail

Newspaper Yelp Event

Family/Friend My Insurance Plan

TV Outside Ballon/Sign

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guarantor** *if the patient is a minor, do you have legal custody?* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship to Patient (Spouse/Parent/Tutor/Legal Guardian/Other):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_

Gender (Male/Female): \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**  *in case of emergency please provide the following information:*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical History

Personal Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_ Your current health is (Good/Regular/Poor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician? (Yes/No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any prescription/over the counter drugs? (Yes/No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list each one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke tobacco in any way? (Yes/No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have or have you ever had any of the following?**

Please select all that apply:

Abnormal Bleeding  Hay Fever  Rheumatic/Scarlet Fever



AIDS, HIV+  Heart Attack  Seizures



Alcohol or Drug Abuse  Heart Surgery  Shingles



Anemia  Heart Murmur  Sickle Cell Disease



 Arthritis  Hemophilia  Sinus Problems

 Artificial Bones/Joints/Valves  Hepatitis  Stroke

 Asthma  Herpes, Fever Blisters  Thyroid Problems

 Blood Transfusion  High Blood Pressure  Tuberculosis Ulcers

 Cancer, Chemotherapy  Kidney Problems  Colitis

 Liver Disease  Congenital Heart Defect  Low Blood Pressure

 Diabetes Difficulty Breathing  Lupus Pacemaker

Epilepsy  Mitral Valve prolapse Fainting Spells

Frequent Headaches  Psychiatric Problems Radiation Treatment

Glaucoma Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Dental History

Why have you come to the dentist today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in pain? (Yes/No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a problem with any previous dental work? (Yes/No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your gums bleed? (Yes/No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times a week do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times a week do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement:**

I acknowledge that this information is correct and will be held in the strictest confidence.

I authorize Smiley Dental to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any copayment and deductibles that my insurance does not cover. I also undertake to cover all legal and collections cost incurred by Smiley Dental for recovery of payment. I hereby authorize payment directly to Smiley Dental of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company. Please type your full first and last name and date to represent your signature. You may also sign this form once you arrive to the office for your appointment.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any of the following?**

Please Select all that apply:

Aspirin Penicillin Jewelry Latex Codeine Azythromycin

Erythromycin Tetracycline Dental Anesthetics Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Women:**

Are you taking birth control pills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, Week # \_\_\_\_\_\_\_\_\_\_

Are you nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use Only:**

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Doctor’s Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UPDATE:

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_