WELCOME

SMITH FAMILY DENTISTRY

1417 Market St. Charlestown, IN 47111 Office: 812-256-2143 Fax: 812-256-0420

PATIENT INFORMATION

Last Name:	First Name:	MI:
Date of Birth: / /	Gender:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Mailing Address:		
City:	State:	Zip:
E-mail Address:		
Employer:		Occupation:
Emergency Contact:	**Phone:**	**Relationship:**
Referred By:		
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Spouse's Name:		
Do you have children? ☐ Yes ☐ No	How many?	

INSURANCE INFORMATION

Primary Dental Insurance Company Name:		
Address:		
City:	State:	Zip:
Phone #: ( )		
Insured's ID #:		
Group #:		
Subscriber's Name:	Date of Birth: / /	Relationship:
Secondary Dental Insurance Company Name:		
Address:		
City:	State:	Zip:
Phone #: ( )		
Insured's ID #:		
Group #:		
Subscriber's Name:	Date of Birth: / /	Relationship:

CONTINUE ON BACK

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking, or popping jaw	☐ Lost/Broken Filling(s)	☐ Stained Teeth	☐ Broken/Chipped Teeth
☐ Blisters/Sores around the mouth	☐ Teeth Grinding	☐ Locking Jaw	☐ Sensitive Teeth or Gums
☐ Red, Swollen, or Bleeding Gums	☐ Ringing in Ears	☐ Bad Breath	☐ Decay/Cavities

☐ Other: _____

Has a physician or dentist recommended that you take antibiotics before having dental work? ☐ NO ☐ YES

If Yes, please list the reason: _____

Previous Dentist Name: _____ Last Dental Visit: _____

Have you had problems with previous dental treatment? ☐ No ☐ Yes

If yes, explain: _____

Do you use tobacco? ☐ No ☐ Yes Type? ☐ Cigarettes ☐ Smokeless Tobacco ☐ Pipe How long? _____

Times a day you brush? _____ Times a week you floss? _____ Type of toothbrush bristles? ☐ Soft ☐ Medium ☐ Hard

Things you would like to change about your smile? _____

MEDICAL HISTORY & INFORMATION

Do you have or have you had any of the following diseases, medical conditions, or procedures?

If <u>none</u> apply, please check here: ☐ NONE

☐ Heart Murmur	☐ Heart Attack/Stroke	☐ Congenital Heart Defect	☐ Cancer/Tumor(s)/Growth(s)	☐ Shingles
☐ Lung Disease	☐ Thyroid Problems	☐ Artificial Heart Valve	☐ Chemotherapy	☐ Hepatitis
☐ Liver Problems	☐ Seizures/Epilepsy	☐ Mitral Valve Prolapse	☐ Radiation	☐ Glaucoma
☐ Blood Disease	☐ Cosmetic Surgery	☐ G.I. Problems/Ulcers	☐ Frequent Thirst	☐ Arthritis/Gout
☐ Kidney Problems	☐ Dizziness/Fainting	☐ Emphysema/Asthma	☐ Frequent Urination	☐ Leukemia
☐ Scarlet Fever	☐ Cold/Fever Blisters	☐ Diabetes/Hypoglycemia	☐ Bleeding Problem/Anemia	☐ Chest Pains
☐ Tuberculosis TB	☐ Blood Transfusion	☐ Psychiatric Problems	☐ High or Low Blood Pressure	☐ Bruise Easily
☐ HIV+/AIDS/ARC	☐ Alcohol/Drug Abuse	☐ Back/Neck Problems	☐ Artificial Bones/Joints/Implants	☐ Allergies
☐ Rheumatic Fever	☐ Eating Disorder	☐ Respiratory Problems	☐ Severe/Frequent Headaches	☐ Nervousness
☐ Sinus Problems	☐ Heart Surg./Pacemaker	☐ Heart Disease/Angina	☐ Jaw Problems	☐ Sleep Apnea

Please list past surgeries or medical conditions: _____

_____

Are you allergic to any of the following? If <u>NO</u> allergies, please check here: ☐ NONE

☐ Latex ☐ Penicillin ☐ Amoxicillin ☐ Codeine ☐ Tetracycline ☐ Dental Anesthetics ☐ Aspirin

☐ Foods: _____ ☐ Other Allergies: _____

Are you taking a blood thinner? ☐ No ☐ Yes If Yes, please list the name: _____

List any other medications you are taking: (If you have a list, please provide it to us and we will make a copy)

_____ _____ _____ _____

_____ _____ _____ _____

FOR WOMEN: Are you taking Birth Control Pills? ☐ No ☐ Yes Are you pregnant? ☐ No ☐ Yes How long? _____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Notice of Privacy Practice. _____

Initials

Signature _____ Date: _____/_____/_____.