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: ( )
Address:		
City:	State:	Zip:
Emergency Contact:	**Phone:**	**Relationship:**
Referred By:		

PARENT/GUARDIAN INFORMATION

Who is accompanying this child today?		Relationship:
Mother's Name:		Date of Birth: / /
Address (if different from patient's):		
City:	State:	Zip:
☐ Stepmother ☐ Guardian		
Father's Name:		Date of Birth: / /
Address (if different from patient's):		
City:	State:	Zip:
☐ Stepfather ☐ Guardian		

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 Is the patient 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 the patient take antibiotics before having dental work? ☐ NO ☐ YES

If Yes, please list the reason: _____

Previous Dentist Name: _____ Last Dental Visit: _____

Has the patient had problems with previous dental treatment? ☐ No ☐ Yes

If yes, explain: _____

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

Times a day patient brushes? _____ Times a week patient flosses? _____ Type of toothbrush bristles? ☐ Soft ☐ Medium ☐ Hard

MEDICAL HISTORY & INFORMATION

Does the patient have, or have they 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: _____

_____

Is the patient 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: _____

Does the patient take a blood thinner? ☐ No ☐ Yes **If Yes, please list the name: _____**

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

_____ _____ _____ _____

_____ _____ _____ _____

FOR WOMEN: Does the patient take Birth Control Pills? ☐ No ☐ Yes 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

Parent/Guardian Signature _____ Date: _____/_____/_____.