Welcome

Patient Information

First name: _____Last name: _____Middle Initial: _____

Address: _____Apt. Number: _____

City:_____ State:_____ Zip: _____

Home phone :(_____) _____-_____ Cell: (_____) _____-_____ Email address: _____

Birth Date: _____ Age: _____ Social Security #: _____ Sex: □ Male □ Female

Marital Status: □ Married □Single □ Divorced □ Separated □ Widowed Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer: _____ City, State: _____ Work phone: (_____) _____-_____

Student Status: □ Full Time □ Part Time Name of School_____ City, State: _____

Main Dental concern: _____

Do you use a pre-medication prior to dental treatment (Anti-biotic)? _____

How did you find our office? (Referral Source)_____

EMERGENCY CONTACT _____ Phone :(_____) _____-_____

Responsible Party (if someone other than patient)

First name: _____Last name: _____Middle Initial:_____

Home phone :(_____) _____-_____ Work phone: (_____) _____-_____ Cell: (_____) _____-_____

Birth Date: _____ Soc. Sec: _____ Relationship to Patient: _____

□ Responsible party is also the Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Holder

Insurance Information (please provide insurance card)

Name of Policy Holder: _____ **Policy Holder Birth Date**: _____

Relationship of patient: □ Self □ Spouse □ Child □ Other Policy Holder SSN-or-**ID #**:_____

Address (if different than patients):_____

City:_____ State:_____ Zip: _____

Name of Policy Holder's Employer: _____ City, State: _____

Name of Insurance Company: _____ Address: _____

City:_____ State:_____ Zip: _____

Dental History

Reason for today's visit _____ Date of last dental Care _____ Date of last x-rays _____

Former Dentist_____ Address _____

Check (✓) if you had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you Floss? _____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-Phen?" These include combinations of lonimin, Adipex, fastin (brand names of phentermine), Pondimin (fenfluramine) and redux (dexfenfluramine). □ Yes □No

Have you ever had any serious illness or operations? □ Yes □ No If yes describe _____

Have you ever had a blood transfusion? □ Yes ■ No If yes give approximate dates _____

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics

☐ Other If yes, please explain:_____

Do you have, or have you had any of the following?

AIDS/HIV Positive	☐Yes ☐No	Fainting	☐Yes ☐No	Skin Rash	☐Yes ☐No
Anemia	☐Yes ☐No	Glaucoma	☐Yes ☐No	Stroke	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Headaches	☐Yes ☐No	Swelling of Feet/Ankles	☐Yes ☐No
Artificial heart Valves	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Problems	☐Yes ☐No	Tobacco	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Blood Disease	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Ulcer	☐Yes ☐No
Cancer	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Pacemaker	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Liver Disease	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Diabetes	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Cough Persistent	☐Yes ☐No	Epilepsy	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Cough up Blood	☐Yes ☐No	Shortness of Breath	☐Yes ☐No		

Medications

List medications you are currently taking

_____

_____

Authorization

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to

Name of insurance company (ies)

Friendship Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named office may use my health care information to above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient