smile partnerz

DENTAL HEALTH FORM

PATIENT INFORMATION

Date _____

SS # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ❑ M ❑ F

Birthdate _____

❑ Married ❑ Single ❑ Divorced

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

Birthdate _____

SS # _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 dentist may use my health care information and may disclose such information to the 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

_____
Date Relationship to Patient

PHONE NUMBERS

Home ( ) _____ Work ( ) _____ Ext _____ Cell Phone ( ) _____

Spouse's Work ( ) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home ( ) _____ Work Phone ( ) _____

CREDIT CARD ON FILE

We will bill your insurance carrier for services provided and will accept assignment of benefits. **However, we will bill your credit card for any unpaid balances.**

Name of cardholder _____ Credit card number _____

Expiration date _____ Billing zip code _____

Signature _____

HEALTH HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following"

AIDS/HIV	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Hepatitis Type _____	❑ Yes	❑ No	Swollen Feet or Ankles	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Tumor or Growth on head or neck	❑ Yes	❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No			
Cancer	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No			
Chemical Dependency	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No			
Circulatory Problems	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No			
Congenital Heart Lesions	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No			
Diabetes	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No			
Emphysema	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No			
Epilepsy	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No			
Fainting or dizziness	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No			
Glaucoma	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No			
Headaches	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No			

Women:

Are you pregnant? ❑ Yes ❑ No Due Date _____ Are you nursing? ❑ Yes

Taking birth control pills? ❑ Yes ❑ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone ( ) _____

ALLERGIES

❑ Aspirin ❑ Local Anesthesia

❑ Barbiturates (Sleeping pills) ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Iodine ❑ Other _____

❑ Latex _____

DENTAL HISTORY

Reason for today's visit _____

_____

Do you snore? ❑ Yes ❑ No

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	❑ Yes	❑ No	Chew on one side of mouth	❑ Yes	❑ No	Orthodontic treatment	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No	Cigarette, pipe or cigar smoking	❑ Yes	❑ No	Sensitivity to cold	❑ Yes	❑ No
			Clicking or popping jaw	❑ Yes	❑ No	Sensitivity to heat	❑ Yes	❑ No
			Dry mouth	❑ Yes	❑ No	Sensitivity to sweets	❑ Yes	❑ No
			Food collection between teeth	❑ Yes	❑ No	Sensitivity when biting	❑ Yes	
			Grinding teeth	❑ Yes	❑ No			
			Gums swollen or tender	❑ Yes	❑ No	How often do you floss? _____		
			Jaw pain or tiredness	❑ Yes	❑ No	How often do you brush? _____		
			Lip or cheek biting	❑ Yes	❑ No			