WELCOME – Adult Dental

To assist us in providing the most comprehensive care, please provide the following information.

PERSONAL INFORMATION

Name: _____
First Middle Last

Home Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone #: (_____) _____ Cell #: (_____) _____

Date of Birth: _____/_____/ _____ Age: _____ Sex: _____ Social Security #: _____

Emergency Contact: _____ Phone #_____

How did you hear about our office? _____

INSURANCE INFORMATION

Policy Holder: _____

Date of Birth: _____ Social Security #: _____

Member ID: _____ Group #: _____

Employer Name and Address: _____

Relationship to Patient: _____

Name of Insurance Company: _____ Telephone # of Insurance Company: (_____) _____

Address to Send Dental Claims: _____

AUTHORIZATION

The information I provided is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of changes in medical status.

Adult Consent:
I am the patient, _____, and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services.

Insurance Assignment and Release:
I certify that I am covered by insurance with _____. I assign directly to A Smile 4U all insurance benefits. 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.

A Smile 4U may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Date

PLEASE COMPLETE BOTH SIDES

PATIENT MEDICAL HISTORY

Patient's Physician: _____ Phone #: _____

Date of last physical examination: _____ Are you currently under the care of a physician? Yes No

If *yes*, explain: _____

For Women: Are you taking birth control pills? Yes No / Are you pregnant? Yes No - Due Date: _____ Are you nursing? Yes No

Please list current prescription medications: _____

_____

Y N Have you taken (currently or previously) bone loss prevention medication such as Fosamax, Actonel, or Boniva?

Are you allergic to any of the following:

Y N	Aspirin	Y N	Amoxicillin	Y N	Augmentin	Y N	Biaxin	Y N	Codeine	Y N	Dental Anesthetics
Y N	Erythromycin	Y N	Ibuprofen	Y N	Keflex	Y N	Latex	Y N	Metals	Y N	Omnicef
Y N	Penicillin	Y N	Sulfa	Y N	Tetracycline	Y N	Zithromax				

Other, if not listed: _____

Do you currently have or have you had the following:

Y N ADD/ADHD
Y N Alcohol/Drug Dependency
Y N Anemia
Y N Anorexia/Bulimia
Y N Artificial Joint(s) (hip/knee)
Y N Asthma
Y N Autism/Asbergers
Y N Bleeding Abnormally with Extraction
Y N Blood Disease
Y N Cardiac Pacemaker
Y N Cancer / Chemotherapy / Radiation Treatment
Y N Congenital Heart Defect
Y N Cough (Chronic)
Y N Cold Sores/Fever Blisters
Y N Diabetes
Y N Emphysema
Y N Environmental Allergies
Y N Epilepsy or Seizures
Y N Fainting
Y N Headaches (Frequent)
Y N Hearing Concerns
Y N Heart Attack History
Y N Heart Disease/Angina
Y N Heart Murmur
Y N Heart Surgery
Y N Heart Valve Defect
Y N Hemophilia/Blood Transfusion
Y N Hepatitis (A, B, C) / Liver Disease
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Nervousness/Anxiety
Y N Pre-Medication (Antibiotic before Dental)
Y N Psychiatric Care
Y N Respiratory Disease
Y N Rheumatic/Scarlet Fever
Y N Chicken Pox/Shingles
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Sickle Cell Disease
Y N Sinusitis
Y N Smoke or Tobacco Use
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis

PATIENT DENTAL HISTORY

Do you currently have or have you had the following?

Y N Tooth sensitivity to hot, cold &/or sweet
Y N Frequent fever blisters, mouth ulcers
Y N Burning of tongue &/or cracking of the corners of mouth
Y N Permanent teeth removed (wisdom teeth)
Y N Any head, neck or jaw injuries
Y N Any popping, clicking or soreness of the jaws
Y N Teeth clenching &/or grinding
Y N Do you wear night guards?
Y N Do you wear dentures &/or partials?
Y N Concerns with teeth/fillings breaking
Y N Concerns with teeth, gums, or mouth
Y N Do you brush 2 times per day?
Y N Do you floss daily?
Y N Does food catch between teeth?
Y N Do you have periodontal disease?
Y N Have you had scaling and root planing?
Y N Gum bleeding while brushing &/or flossing
Y N Unpleasant taste &/or odor in your mouth
Y N Do you chew on one side of your mouth?
Y N Do you bite your lips &/or cheeks?
Y N Are you a mouth breather?
Y N Sleep apnea
Y N Are you happy with your smile?
Y N Are you interested in braces (orthodontics)?

Recent Dental Checkup/Cleaning:

Date: _____ By Whom: _____

Date of Last: Panoramic Radiograph _____

Bitewing Radiographs _____

Frequency of brushing: _____

Frequency of flossing: _____

DR. HAS REVIEWED THE PATIENT MEDICAL & DENTAL HISTORY:

DR'S INITIALS _____ DATE: _____