Date: ____________________
Check-in Time: ____________________
Appointment Time: ____________________

PATIENT INFORMATION

Patient Name: ____________________________________

Age: __________ Date of Birth: _____________________

Mailing Address: __________________________________

____

Cell #: ________________________________

Home #: ________________________________

E-mail: ____

Name of Insurance: ________________________________

HEALTH HISTORY (Please circle yes or no if you have had any of the following)

Heart Disease/Problems	Yes	No	Asthma	Yes	No	Epilepsy or Seizures	Yes	No
Heart Attack	Yes	No	Cerebral Palsy	Yes	No	Nervousness	Yes	No
Heart Failure	Yes	No	ADD/ADHD	Yes	No	Fainting/Dizzy Spells	Yes	No
Heart Murmur	Yes	No	Autism	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Blood Transfusion	Yes	No	Kidney Disease	Yes	No
Congenital Heart Disease	Yes	No	Bleeding Abnormally	Yes	No	Radiation Therapy	Yes	No
Heart Surgery	Yes	No	Bruise Easily	Yes	No	Cancer	Yes	No
Heart Pacemaker	Yes	No	Anemia	Yes	No	Thyroid	Yes	No
High Blood Pressure	Yes	No	Hepatitis (A) (Infectious)	Yes	No	Ulcers	Yes	No
Stroke	Yes	No	Hepatitis (B) (Serum)	Yes	No	Sickle Cell	Yes	No
Mitral Valve Prolapse	Yes	No	Hepatitis (C)	Yes	No	Psychiatric Treatment	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Drug Addiction	Yes	No
Chronic Cough	Yes	No	Diabetes	Yes	No	Chemical Dependency	Yes	No
Environmental Allergies	Yes	No	Cold Sores/Fever Blisters/Herpes	Yes	No	Artificial Joints (Hip, Knee, Elbow, etc.)	Yes	No
Sinus Issues	Yes	No	AIDS/HIV Positive	Yes	No			

Are you allergic to latex? Yes / No
Are you allergic to local anesthetic? Yes / No
Are you allergic to any medications? Yes / No
If Yes, please list: ____
List any current medications (prescriptions and over-the-counter):____
____

For Women Only: Taking birth control pills? Yes / No Are you pregnant? Yes / No
If yes, please provide due date: ___________

PROXY CONSENT TO TREAT A MINOR

To allow a legal adult other than a parent or legal guardian to serve as a proxy decision maker for dental care services at A Smile 4U in your absence, please review and complete the following information if you also agree to accept financial responsibility for all care delivered pursuant to this authorization, and if you agree that is your responsibility to update this proxy consent with any changes.

_____________________________________ ___________ ; _________________________________ ___________
Name Relationship Name Relationship

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: ____

Parent/Guardian name:________________________ Signature: ______________________ (if patient is a minor under the age of 18)

OFFICE USE ONLY

TREATMENT PLANS

U/R	U/L
L/R	L/L

Next Visit: Hygiene Recall___________________________ **Next Visit: Operatory** ______________________________
Prescribed Medications: ____________________________

PATIENT ASSESSMENT (Please check appropriate box)

Clinical Findings:		Calculus		Plaque		Bleeding		Stain
Gingiva:		Healthy		Gingivitis		Moderate Perio		Advanced Perio
Oral Hygiene:		Good		Fair		Poor		
Behavior:		Good		Fair		Poor		

COMPLETED TREATMENT (Please check appropriate box)

EXAMS		*PROPHY*		*X-RAYS*		*PERIO*	
	D0150 Comprehensive		D1110 Adult		D0220 Periapical 1st		D4355 FMD
	D0120 Periodic		D1120 Child		D0230 Periapical-Add.		D4341 SRP (4+ teeth)
	D0140 Limited		D1206 Topical Application of Fluoride Varnish		D0272 2 Bitewings		D4342 SRP (1-3 teeth)
	D0180 Perio Charting		D1208 Topical Application of Fluoride		D0274 4 Bitewings		D9630 Irrigation
			D1351 Sealants		D0330 Panoramic		D9995 CHX
			D9630 Take Home FL				D4381 Arestin

ORTHODONTIC (Please circle yes/no)

Refer to Ortho	Yes	No	Reason:
Ortho Appointment Made	Yes	No	Reason:
If no Ortho Appointment Made, advise Orthodontic Department to follow-up with Patient			

OTHER REFERRALS (Please check appropriate box)

	IV Sedation		Pedo Specialist		Oral Surgeon		Endodontist	Reason:

CHECK-OUT (Please check appropriate box)

	Progress Notes Completed		Treatment Posted to Ledger
	Treatment Plan Signed by Patient & Status Updated		Treatment Plan Entered

STAFF (Please initial)

	Check-In		X-Ray Tech		Hygienist
	Exam W/Dr.		Dr.		Check-Out