Smiles RESTORED

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date: _____

Full Legal Name: _____ Pref Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Minor

Home Phone: _____ Cell Phone: _____ Text: ❑ Y ❑ N Alt Phone:_____

How would you prefer to be contacted? (please circle) Home Work Cell Text Email: _____

Employer: _____ Employer Phone: _____

Employer Address: _____ City, State, Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Phone: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone: _____

Responsiblity Party If Different From Patient

Person responsible for account: _____ Relationship to patient: _____

Address: _____ Contact Phone: _____

Driver's License #: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

Dental Insurance Information

Insurance Company: _____ Subscriber Name: _____

Relationship to Patient: _____ Date of Birth: _____ Member ID or SSN: _____

Employer: _____ Group Number: _____

Secondary Dental Insurance

Insurance Company: _____ Subscriber Name: _____

Relationship to Patient: _____ Date of Birth: _____ SSN: _____

Employer: _____ Group Number: _____

Dental History

Reason for today's visit: _____ Date of Last Dental Exam: _____

Former Dentist: _____ Date of Last Dental X-rays: _____

Address:_____

Check (X) if you have had problems with 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

Medical History _____

Medical Physician's Name: _____ Date of last visit: _____

Have you taken any of the group of drugs referred to as "fen-phen"? These include a combination of Lonimin, Adipex, Fastin (brand name of Phentermine) and Redux (Dexfenfluramine)? ❑ Yes ❑ No Describe: _____

Have you had any major illnesses or operations? ❑ Yes ❑ No Describe:_____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, date(s): _____

(Women) Are you Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control? ❑ Yes ❑ No

Check (X) if you have had problems with any of the following:

❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valve
❑ Artificial Joints, Pins, etc.
❑ Asthma
❑ Back Problems
❑ Bleeding Abnormally
❑ Blood Disease
❑ Cancer
❑ Chemical Dependancy
❑ Chemotherapy
❑ Circulatory Problems
❑ Congenital Heart Lesions
❑ Cortisone Treatments
❑ Cough, Persistent
❑ Cough up blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis Type _____
❑ Hernia Repair
❑ High Blood Pressure
❑ HIV/AIDS
❑ Jaw Pain
❑ Kidney Disease
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Skin Rash
❑ Stroke
❑ Swelling of feet or ankles
❑ Thyroid Problems
❑ Tobacco Habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer
❑ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

Drug allergies:

Authorization & Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or contact information.

Signature: _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Smiles Restored all insurance benefits, if any, otherwise payable to me for the 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(s) 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.

_____ Date:_____

Signature of Patient, Parent, Guardian, or Personal Representative Relationship to patient: _____

Printed Name: _____