



BEAUTIFUL DENTISTRY | COMFORTABLE CARE

Welcome!

PATIENT INFORMATION	DENTAL INSURANCE
<p>Date _____</p> <p>Patient _____</p> <p>Address _____</p> <p>_____ City _____ State _____ Zip _____</p> <p>Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Patient SS# _____</p> <p>Occupation _____</p> <p>Employer _____</p> <p>Employer Address _____</p> <p>Employer Phone _____</p> <p>Spouse's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Occupation _____</p> <p>Spouse's Employer _____</p> <p>Whom may we thank for referring you? _____</p> <p>_____</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p>Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Subscriber's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p>ASSIGNMENT AND RELEASE I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Lifetime Smiles all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p>Responsible Party Signature _____</p> <p>Relationship to Patient _____ Date _____</p>
CONTACT INFORMATION	
<p>Home # _____ Work # _____ Ext _____ Cell # _____</p> <p>Spouse's Work # _____ Ext _____ Spouse's Cell # _____</p> <p>E-Mail Address _____</p> <p>IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)</p> <p>Name _____ Relationship _____</p> <p>Home Phone # _____ Work Phone # _____</p>	

Please Complete Both Sides

HEALTH HISTORY

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

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____	
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacements (hip, knee or other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been told you need antibiotics prior to dental treatment due to your prosthetic replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No			Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No			Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Weight Loss unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICATIONS

List medications you are currently taking: _____
Have you, are you or will you be taking bisphosphonates medication (alendronate-Fosamax, risedronate-Actonel or IV drugs - Aredia or Zometa) for osteoporosis, Paget's disease or for any other reason? Yes No
Have you ever taken Fen-Phen? Yes No Have you ever taken Redux? Yes No

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Other _____
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	_____
	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa	_____

DENTAL HISTORY

Reason for Today's Visit _____
Former Dentist (optional) _____
Address _____
Date of last dental care _____ Date of last dental X-rays _____
Do you suffer from headaches? Yes No Are you interested in whitening your teeth? Yes No
Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in your mouth
<input type="checkbox"/> Sensitivity to pressure		

How often do you floss? _____ How often do you brush? _____