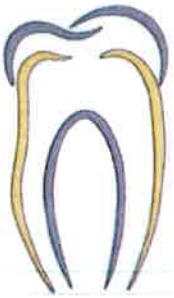


Designing Dental Smiles, PLLC Date_____

Name_____
Social Security #_____
Address_____ Email_____
City_____ State_____ Zip Code_____
Home Phone #_____ Cell #_____
Work #_____
Age_____ Date of Birth_____ Sex M F
Whom may we thank for referring you?_____
In case of emergency who should be notified?_____ Phone #_____

Primary Insurance Information

Name of Primary Insurance Holder _____ Relation to Patient_____
Birth Day _____
Social Security #_____
Employed by?_____BusinessAddress_____
Insurance Company Name_____ Contract #_____ Group # _____
Subscriber # _____
Name of dependants covered under this Plan_____

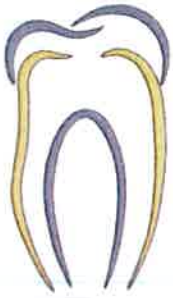
Secondary Insurance Information

Name of Secondary Insurance Holder _____ Relation to Patient_____
Birth Day _____
Social Security #_____Employed by?_____
Business Address_____
Insurance Company Name_____ Contract #_____ Group # _____
Subscriber # _____
Name of dependants covered under this Plan_____

Authorization

I certify that I or my dependents , have dental insurance coverage with _____ and assign directly to Designing Dental Smiles PLLC, 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-names dentist may use my health care information and may disclose such information to the above-names Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

- Signature of Patient, Guardian or Personal Representative_____Date_____
- Please print name of Patient, Guardian or Personal Representative_____



Designing Dental Smiles, PLLC

Dental History

Reason for today's Visit?_____ Date of last dental care_____ Date of last x-rays_____

Former Dentist_____ Address_____

Please (check) if you have a problem with any of the following:

	Bad Breath		Broken Fillings		Food Collection between teeth
	Teeth Grinding		Sensitivity to Sweets		Sensitivity to cold
	Sensitivity to Hot		Clicking or popping jaw		Sores or growths in your mouth
	Bleeding Gums		Periodontal Treatments		
	Loose Teeth		Sensitivity when biting		

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

Medical History

Primary Care Physician's Name _____Phone #_____ Date of Last Visit_____

Have you ever had any serious illnesses or operations? Yes or No _____

Have you ever had a blood transfusion? Yes or No _____

(Women) Are you pregnant? Yes or No * Nursing? Yes or No * Taking birth control pills? Yes or No

Please (check) if you have OR have had any of the following:

	Anemia		Cortisone Treatments		Hepatitis		Scarlet Fever
	Arthritis, Rheumatism		Cough, Persistent		High Blood Pressure		Shortness of Breath
	Artificial Joints		Cough up Blood		HIV/AIDS		Skin Rash
	Asthma		Diabetes		Jaw Pain		Stroke
	Back Problems		Epilepsy		Kidney Disease		Swelling of Feet and Ankles
	Blood Diseases		Fainting		Liver Diseases		Thyroid Problems
	Cancer		Glaucoma		Mitral Valve Prolapse		Tobacco Habit
	Chemical Dependency		Headaches		Pacemaker		Tonsillitis
	Chemotherapy		Heart Murmur		Radiation Treatment		Tuberculosis
	Circulatory Problems		Heart Problems		Respiratory Disease		Ulcer
	Artificial Heart Valves		Hemophilia		Rheumatic Fever		Venereal Disease

Allergies

	Aspirin
	Ibuprofen/Motrin
	Sulfa Drugs
	Penicillin
	Codeine
	Latex
	Local Anesthetics Novocain
	Azithromycian
	Tylenol
	Other

List Medications, doses, and reason that you are currently taking, or attach list
