Smiles By Design

Patient Information Form

_____

Name

_____

Name you wish to be Called Home Phone

_____

Address

_____

City, State, Zip

_____

E-Mail Cell Phone

_____

Employer

_____

Business Address

_____

Business Phone Occupation

_____

Date of Birth Marital Status

_____

Spouse or Name of Parent

_____

Emergency Contact Phone

_____

I was Referred By

_____

SSN of Patient

_____

SSN of Primary Insurance Holder

Acknowledgment

I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that I am to report any changes in my health to the dental office as soon as possible. I have read, and understand each question, and have answered all of them truthfully and to the best of my ability. I have discussed my health history with a doctor.

I understand that my responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time such services are rendered.

I understand there is a 3 month grace period with no interest after which there is a 1.5 % monthly finance charge to unpaid balances.

_____

Signature of Patient or Responsible Party Date

_____

Relationship to Patient

Review Date: Initials:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical Information

	Yes	No
Are you currently under a physician's care?	___	___
If yes please explain: _____		
Have you been hospitalized within the past two years?	___	___
Have you ever needed to pre-medicate prior to Dental treatment? If yes, what for? _____	___	___
Have you had radiation treatment or Chemotherapy in the past year?	___	___
Are you taking any drugs or medications?	___	___

Name_____
_____
_____

To the best of your knowledge do you no or have you ever had:

Heart Conditions?	___	___
Rheumatic Fever?	___	___
Heart Murmur?	___	___
Mitral Valve Prolapse?	___	___
Diabetes/ Healing Complications?	___	___
Epilepsy?	___	___
Respiratory Disease?	___	___
Fainting Spells?	___	___
Prolonged Bleeding?	___	___
Are you pregnant or trying to get pregnant?	___	___
Sinus Problems?	___	___
Headaches?	___	___
Ear Problems?	___	___
Nervous or Mental Problems?	___	___
Do you use Tobacco? Packs a Day? ___	___	___
Allergy to any Drugs or Medications?	___	___
Names: _____		
Do you have any reactions (skin) to Jewelry?	___	___

	Yes	No
Do you have any artificial joint prostheses?	___	___
Do you have an artificial heart valve?	___	___
Have you tested positive for HIV virus	___	___
Have you been diagnosed as having AIDS or Aids related Complex?	___	___
Have you ever been diagnosed as having any Venereal disease?	___	___
List_____		
Have you ever been diagnosed as having Hepatitis?	___	___
Are you on a special diet for any purpose?	___	___
Type _____		
Do you take any vitamin or mineral supplements?	___	___
List_____		
_____		
Do you have any diseases or condition or problem not listed ?	___	___
Is there any other information you would like us to Know about you?	___	___

Name of Physician:_____

Phone number_____

Date of last exam_____