Front

Smile Innovations
Get Acquainted Questionnaire

PATIENT'S NAME ______________________________
LAST FIRST MIDDLE DATE OF BIRTH

Residence Address ______________________________ Phone ( ) ______________

City ______________________________ State __________ Zip __________

Driver's License No. ______________________________ Social Security No. ______________

(please circle one) Married (Name of Spouse ______________________________) Single Widowed Divorced

Whom may we thank for referring you to our office? ______________________________

Person responsible for payment of account ______________________________

YOUR EMPLOYER ______________________________ SPOUSE EMPLOYER ______________________________

Business Address ______________________________ Business Address ______________________________

City ______________ Zip __________ City ______________ Zip __________

Business Phone ( ) ______________ Business Phone ( ) ______________

Please complete the following if patient is covered by dental insurance:

Insured's Name ______________________________ Social Security No. ______________

Insurance Co. Name and Address ______________________________

Insured's Employer ______________________________ Group No. ______________ Local No. ______________

If patient has double coverage, complete this for the secondary carrier:

Insured's Name ______________________________ Social Security No. ______________

Insurance Co. Name and Address ______________________________

Insured's Employer ______________________________ Group No. ______________ Local No. ______________

YOUR DENTAL HISTORY

Do you have a fixed bridge? ______________ A removable partial? ______________ A denture? ______________

When were they placed? ______________________________

Former Dentist ______________________________ Date of last dental visit ______________

Have you ever had any serious problem associated with previous dental treatment? ______________

If so, please explain ______________________________

Do you have any PRESENT DENTAL PROBLEMS? ______________________________

How often do you brush your teeth? ______________ How often do you floss? ______________

Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)

Do your gums BLEED, or feel TENDER, IRRITATED or SWOLLEN? ______________

Are you aware of GRINDING or CLENCHING your teeth? ______________

Do you have HEADACHES, EARACHES, or NECK PAINS? ______________

Are you aware of any swelling, lump or unhealed injuries in or around your mouth? ______________

Do you have any LOOSE, TIPPED or SHIFTING teeth? (circle)

Are you unhappy with the APPEARANCE of your teeth? ______________

Do you have DISCOLORED teeth? ______________ Would you like your smile to look better or different? ______________

How do you feel about your teeth? ______________________________

It is a pleasure to survey your dental needs and discuss these problems with you. Should you choose to place the care of your dental health with us, please be assured that the most thorough, conscientious service will be dedicated to this trust. All facilities and personnel of this office are expressly here to serve you and your health.

Back

Health History Update

Patient's Name ______________________ **Email Address** ______________________

Birthdate ______________________

Do you have any current health problems? .... Yes_______ No _______

Are you under the care of a physician now? .... Yes_______ No _______

If so, for what? ______________________

Are you currently taking any medication? .... Yes_______ No _______

If yes, what? ______________________

Circle any of the following which you have had or have at present:

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Rheumatic Fever
Congenital Heart Disease
Mitral Valve Prolapse
Artificial Heart Valves
Heart Pacemaker
Heart Surgery
Artificial Joints (hip, knee)
Anemia
Stroke
Chemotherapy

AIDS
Hepatitus A (infectious)
Hepatitus B (serum)
Liver Disease
Blood Transfusion
Drug Dependence
Hemophilia
Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Glaucoma
Bruise Easily

Emphysema
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergy
Diabetes
Thyroid Disease
Radiation Treatment
Arthritis
Rheumatoid Arthritis
Kidney Disease
Ulcers

Are you allergic or have you reacted adversely to any of the following:

Asprin
Sulfa Drugs
Nitrous Oxide

Percodan
Novacaine
Codeine

Erythromycin
Valium
Penicillin

Are you aware of being allergic to any other medication or substance? ______________________

Is there any other Medical or Dental Information that you feel we should know?

____

ASSIGNMENT

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________ Date ______________________

Payment is due in full at time of treatment unless prior arrangements have been approved.