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? _____

Are you unhappy with the APPEARANCE of your teeth? _____

Do you have DISCOLORED teeth? _____ Would you like to whiten 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.

Health History Update

Patient's Name _____ **Birthdate** _____

Email Address _____ **Cell Phone** _____

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

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxia
Anemia
Angina Pectoris
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Bisphospinate Drugs
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
GERD
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Venereal Disease

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:_____

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

Asprin Codeine Penicillin Metal Valium Latex Sulfa Drugs

Any Other Allergies? _____

Are you taking any medications, pills or drugs? ◯ Yes ◯ No If yes, please explain: _____

_____

Are you under a physicians care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Do you use Tabacco? ◯ Yes ◯ No Type/Duration: _____

Have you ever taken antiboitics prior to having your teeth cleaned or before dental work?

◯ Yes ◯ No If yes, please explain:_____

Female clients: Are you pregnant ◯ Yes ◯ No

Any other medical/dental conditions that the dentist should know about? _____

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.