

# Welcome to Great Smiles Family Dentistry

## Patient Information (Confidential)

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell/Pager No. \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Patient's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Spouses Name \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Responsible Party

Name of person responsible for account \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

## Insurance Information

Name of insured \_\_\_\_\_ Relation to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_

Ins. Address \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_ How much have you used? \_\_\_\_\_

**Do you have any additional dental insurance?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please complete the following

Name of insured \_\_\_\_\_ Relation to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Address \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_ How much have you used? \_\_\_\_\_

## Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of last exam \_\_\_\_\_

**Do you have or have you had any of the following?**

	Yes	No		Yes	No
Mitro-Valve Prolapse	___	___	Heart Murmur	___	___
Joint Replacement	___	___	Heart Disease	___	___
High Blood Pressure	___	___	Blood Disease	___	___
Diabetes	___	___	Stroke	___	___
Epilepsy	___	___	Seizures	___	___
Arthritis	___	___	Tumor History	___	___
VD	___	___	HIV/AIDS	___	___
Rheumatic Fever	___	___	Heart Attack	___	___
Asthma	___	___	Low Blood Pressure	___	___
Leukemia	___	___	Kidney Disease	___	___
Thyroid Problem	___	___	Pacemaker	___	___
Angina	___	___	Anemia	___	___
Emphysema	___	___	Cancer	___	___
Sinus problems	___	___	Cosmetic Implants	___	___
Hepatitis/Jaundice	___	___	Ulcers	___	___
Chest Pains	___	___	Fever Blisters	___	___
Severe Headaches	___	___	Drug/Alcohol Abuse	___	___
<b>Osteoporosis</b>	___	___	<b>Osteopenia</b>	___	___

**Are you allergic to or have you had any allergic reactions to the following?**

Local anesthetics	___	___	Penicillin/other antibiotics	___	___
Sulfa	___	___	Barbiturates	___	___
Sedatives	___	___	Iodine	___	___
Aspirin	___	___	Any Metals	___	___
Latex Rubber	___	___	Other _____	___	___

**Are you taking any of the following medications?**

Fosamax (alendronate) **---Osteoporosis meds.**      Aredia (pamidronate)  
 Actonel (residrenate) **---Osteoporosis meds.**      Zometa (zoledronate) **---Cancer meds.**  
 Boniva (Ibandronate)

**Are you taking any medication? Please list: \_\_\_\_\_**

Are you pregnant or think you may be pregnant? \_\_\_\_\_ Are you nursing? \_\_\_\_\_  
 Are you taking oral contraceptives? \_\_\_\_\_

**Patient Dental History**

Name of previous dentist _____	Date of last exam _____
	Yes      No
Do your gums bleed while brushing/flossing	___      ___
Are your teeth sensitive to hot/cold	___      ___
Do you feel pain to any of your teeth	___      ___
Have you had any orthodontic treatment	___      ___
Do you have any sores or lumps in your mouth	___      ___
Have you experienced any of the following:	
Clicking?	___      ___
Pain (joint, ear, side of face)	___      ___
Difficulty opening or closing mouth	___      ___
Difficulty in chewing	___      ___
Would you be interested in whitening your teeth	___      ___
	Yes      No
Do you clench or grind	___      ___
Do you bite your cheeks	___      ___
Have you ever had any prolonged bleeding following an extraction?	___      ___
Have you had any difficult extractions	___      ___
Do you wear dentures or partials	___      ___
Have you ever received oral hygiene instructions re: teeth & gums	___      ___
Do you snore	___      ___
Do you like your smile	___      ___
Do you have any dental implants	___      ___

**Authorization and Release**

The above medical history is complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination to third party payors and/or health practitioners. I understand that my dental carrier may pay less than the actual bill for services, and I agree to be responsible for payment of all services rendered on my behalf or my dependents. I acknowledge having received a copy of Great Smiles Family Dentistry notice of patient privacy practices.

Date \_\_\_\_\_ Signature \_\_\_\_\_ Relation \_\_\_\_\_