Welcome to Great Smiles Family Dentistry

Patient Information *(Confidential)*

Name:_____ SS#:_____ Birthdate:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work phone:_____ Cell/Pager No.:_____

Email Address: _____

Patient's Employer:_____ Occupation:_____

Single____ Married____ Widowed____ Spouse 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 deductable? _____ 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 deductable? _____ 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		
Osteoparosis			**Osteopenia**		

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

Local anesthetics			Penicillian / other antibiotics		
Sulfa			Barbiturates		
Sedatives			Iodine		
Asprin			Any Metals		
Latex Rubber			Other		
			Do You Smoke?		

Are you taking any of the following medications?

Fosamax (alendronate)			Aredia (pamidronate)		
Actonel (residrenate)			Zometa (zoledronate)		
Osteoporosis meds			**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

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

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: _____