Smith & Cole
Laser & Cosmetic Family Dentistry

WELCOME

Today's Date: _____

About you

Name: _____ prefer to be called: _____
Last First MI Mr. Mrs. Ms. Dr.

Home Address: _____
Street City State Zip

Home Phone #: (_____)_____ Work Phone #: (_____)_____ Cell Phone #: (_____)_____

Email: _____ Birthdate: _____/_____/_____ ❑ Male ❑ Female

Marital: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated Age: _____ Social Security #: _____

Emergency Contact: _____ Phone: (_____)_____

Where & when are best times to reach you? _____ Who may we *thank* for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Person responsible for account if other than yourself

Name: _____ Relation: _____ Home Phone: (_____)_____ Social Security # _____

Employer: _____ Work Phone #: (_____)_____ Ext. _____ Driver's License # _____

Billing Address: _____
Street City State Zip

Spouse information

His/Her Name: _____ Birthdate: ____/____/____

Employer: _____ Cell Phone #: (_____)_____ Work Phone #: (_____)_____ Ext. _____

Social Security #: _____ Driver's License # _____

Dental insurance information

Primary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address. _____
Street City State Zip

Insured's Name: _____ Insured's Social Security # _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address. _____
Street City State Zip

Insured's Name: _____ Insured's Social Security # _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is … ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Do your gums ever bleed? ❑ Yes ❑ No Ever itch? ❑ Yes ❑ No

Would you like fresher breath? ❑ Yes ❑ No

Would you like to have whiter teeth? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ❑ Yes ❑ No

If yes, explain: _____

Have you ever had injury to your face or jaw? ❑ Yes ❑ No

Previous/Present Dentist: _____ Last visit: _____

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street/PO Box City State Zip

Phone #: (____)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever been hospitalized or had any surgeries? Please explain: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Iodine	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions:

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

weeks: _____ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen (Tylenol)	Y N Blood Pressure Medication	Y N Insulin / Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Bone Density Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	Have you ever taken Phen-Fen? Also known as Redux or Podinmin. ❑ Yes ❑ No
Y N Aspirins	Y N Digitalis/Heart Medication	Y N Steroids / Cortisone	
Y N Blood Thinners			

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one:

_____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis-Type: _____	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for any reason	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying and co-payment and deductable that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date