WELCOME

email: todayssmile6565@gmail.com
website: www.todayssmile.net

PATIENT INFORMATION

Patient ______________________ Date __________

Home Address ______________________

Mailing Address ______________________

____
City State Zip

Sex: ☐ M ☐ F Age ________ Birthdate __________

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Patient SS #______________________

Occupation ______________________

Employer ______________________

Employer's Address ______________________

Employer's Phone ______________________

Spouse's Name ______________________

Birthdate ______________________

Occupation ______________________

Spouse's Employer ______________________

Spouse's Employer Address ______________________

Spouse's Employer Phone ______________________

Whom may we thank for referring you? ______________________

DENTAL INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, Insurance Co. ______________________

Subscriber's Name ______________________

Birthdate __________ SS #__________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party's Signature

______________________ __________
Relationship Date

PHONE NUMBERS

Home __________ Work __________ Ext. ______ Cell __________ Spouse's Work __________

Best time and place to reach you ______________________ Email: ______________________

EMERGENCY CONTACT: (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone __________ Work Phone __________ Cell Phone __________

DENTAL HISTORY

Reason for today's visit ______________________

____

Former Dentist ______________________

City/State ______________________

Date of last dental visit ______________________

Date of last dental x-rays ______________________

If you had a magic wand, what would you change about your teeth?

____

Please mark "Yes" or "No" to indicate if you have or had any of the following:

Condition	Yes	No
Bad taste	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dark teeth	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken filling	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold/heat/sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No
Unsightly teeth	☐ Yes	☐ No

How often do you floss? ______________________

How often do you brush? ______________________

HEALTH HISTORY

Physician's Name ______________________ Date of last visit ____________

Physician's Address ______________________

Please mark "Yes" or "No" to indicate if you have or had any of the following:

Condition	Yes	No
AIDS	☐ Yes	☐ No
Alcohol use	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problem	☐ Yes	☐ No
Bleeding abnormally, w/ extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problem	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No
Congenital Heart Lesion	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Drug/Alcohol rehabilitation	☐ Yes	☐ No
Drug use (illegal)	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy/Seizures or Convulsions	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No
Fever Blisters/Mouth Ulcers or Canker Sores	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Hearing Problem	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problem	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis Type__________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV+	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problem	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Prosthetic Replacement	☐ Yes	☐ No
Psychiatric Treatment	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No
Swelling of Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No
Tobacco use	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor/Growth on Head/Neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Vision Problem/Glaucoma or Cataract	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No
Women: Are you pregnant?	☐ Yes	☐ No
Due date__________		
Are you nursing?	☐ Yes	☐ No

MEDICATIONS

List medications you are currently taking ______________________

____

____

____

List Past surgeries ______________________

Pharmacy's Name ______________ Ph: __________

ALLERGIES

(Causing swelling, rash, hives, itching or difficulty breathing)

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine or other pain meds
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa
- ☐ Other Drugs ______________

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I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT LIMITED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS, AND CONDUCT OF LABORATORY, X-RAY OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR QUALIFIED DESIGNATE. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE. I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY AND NOT AN INSURANCE COMPANY TO PAY FOR ANY OR ALL SERVICES. ANY OUTSTANDING BALANCE AFTER 30 DAYS MAY INCUR A FINANCE CHARGE OF 18% PER ANNUM OR 1-1/2% PER MONTH.

Signed ______________________ ______________ ______________

Patient, Parent or Guardian (Must be 18 years or older) Doctor's Signature Date

OFFICE USE

BLOOD PRESSURE ______________ PULSE ______________

NOTES: ______________________

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