

Wanda Gardiner Smith, D.D.S.
 Restorative and Cosmetic Dentistry
 829 North Jefferson Street
 Wilmington, Delaware 19801
 (302) 656-2584 - Fax (302) 656-2330

Chart # _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other: _____

Social Security #: _____ Birth Date: _____ Driver's License #: _____ State: _____

Phone (Home): _____ (Work): _____ Ext.: _____ Email: _____

Home Address: _____
Street Apartment #

_____ City _____ State _____ Zip Code _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please read this carefully and circle Y for Yes and N for No:

AIDS/HIV	Y N	Head Injuries	Y N	Radiation Treatment	Y N	Penicillin Allergy	Y N
Anemia	Y N	Heart Disease	Y N	Respiratory Problems	Y N	Anesthetic Allergy	Y N
Arthritis	Y N	Heart Murmur	Y N	Rheumatic Fever	Y N		
Artificial Joints	Y N	Hepatitis	Y N	Rheumatism	Y N	Latex Allergy	Y N
Asthma	Y N	High Blood Pressure	Y N	Sinus Problems	Y N	Other Allergies	
Blood Disease	Y N	Jaundice	Y N	Stomach Problems	Y N		
Cancer	Y N	Kidney Disease	Y N	Stroke	Y N	OTHER	
Diabetes	Y N	Liver Disease	Y N	Thyroid Disorder	Y N	<input type="checkbox"/>	
Dizziness	Y N	Psychiatric Treatment	Y N	Tuberculosis	Y N	<input type="checkbox"/>	
Epilepsy	Y N	Nervous Disorders	Y N	Tumors/Cysts	Y N		
Excessive Bleeding	Y N	Pacemaker	Y N	Venereal Disease	Y N		
Fainting	Y N	Pregnancy		ALLERGIES			
Glaucoma	Y N	Due date: _____		Codeine Allergy	Y N		

Official Use Only

Dr:RDH _____

Date _____

- Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____
- Have you ever been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____
- Are you now under the care of a physician? Yes No
 If yes, please explain: _____
 Name of Physician: _____
- Who may we contact in the event of a medical emergency? Name: _____
 Relationship to patient: _____ Day Phone: _____ Eve Phone: _____
- Have you ever taken the medication Fen-Phen or Redux? Yes No
- What medications, vitamins, or herbal remedies are you taking at this time? _____
- Do your gums bleed when you floss or brush? Yes No
- Do you smoke? Yes No If yes, how much do you smoke daily? _____
- Have you ever had an addiction to recreational drugs? Yes No If yes, explain: _____
- Do you have frequent headaches? Yes No Do you clench or grind your teeth? Yes No
- Does your jaw ever get "stuck", "locked", or "go out"? Yes No
- What changes would you like to make to the appearance of your teeth? _____
- Have you ever had an unfavorable reaction to Nitrous Oxide? Yes No If yes, explain: _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X Signature of patient, parent or guardian: _____ Date: _____

PERMISSION TO DENTISTS/HYGIENISTS: I give my consent to use local anesthetic or relaxants for completing necessary dental treatment

X Signature of patient, parent or guardian: _____ Date: _____

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Invisalign Certified
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Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

PacBell Yellow Pages Evergreen Yellow Pages Times Newspaper Other _____

Name of person or office referring you to our practice: _____

Patient Employment

Employer Name: _____ Occupation: _____

Street, City, State, Zip: _____

Employer Phone: _____

Spouse or Guardian Information

The following is for: the patient's spouse parent guardian

Name: _____
 Male Female Married Single Other: _____

Social Security # _____ Birth Date: _____

Phone (Home): _____ Work): _____ Ext.: _____ Best time to call: _____

Home Street Address: _____

City, State, Zip: _____

Employer Name: _____ Occupation: _____

Street, City, State, Zip _____

REGARDING MISSED OR CANCELLED APPOINTMENTS: Once I make an appointment, the time will be reserved for me. If I miss or cancel a dental appointment without 48 hours advance notice, I agree to pay \$25 for each one-half hour of appointment time reserved. This policy is needed to prevent delays of my treatment as well as other patients. I realize that the delay of a missed or cancelled appointment may jeopardize my dental health.

X Signature: _____ Date: _____

IV. PRIMARY INSURANCE COVERAGE INFORMATION

All the information below is required in order for us to submit your claim.

Note: The "subscriber" is the person who carries the insurance for his/her dependents			Patient's Relationship to the Subscriber		
			Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other <input type="checkbox"/>		
			Type of Insurance: <input type="checkbox"/> Dental <input type="checkbox"/> Medical		
Subscriber Name			Subscriber Address		
City	State	ZIP	Subscriber Date of Birth	Subscriber Soc Sec #	Subscriber ID#
Insurance Company Name			Insurance Company Address		
City	State	ZIP	Insurance Phone # ()	Insurance FAX # ()	
Insurance Plan Name		Group Number		Employer Name	
Employer Address		City		State	ZIP

V. SECONDARY INSURANCE COVERAGE INFORMATION

Note: The "subscriber" is the person who carries the insurance for his/her dependents			Patient's Relationship to the Subscriber		
			Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other <input type="checkbox"/>		
			Type of Insurance: <input type="checkbox"/> Dental <input type="checkbox"/> Medical		
Subscriber Name			Subscriber Address		
City	State	ZIP	Subscriber Date of Birth	Subscriber Soc Sec #	Subscriber ID#
Insurance Company Name			Insurance Company Address		
City	State	ZIP	Insurance Phone # ()	Insurance FAX # ()	
Insurance Plan Name		Group Number		Employer Name	
Employer Address		City		State	ZIP

I authorize the office of **Wanda G. Smith, D.D.S.** or my insurance company, to release any information required for payment or review of the claim. I am financially responsible to **Wanda G. Smith, D.D.S.** for all balances due, and assign my benefits to **Wanda G. Smith, D.D.S.**

Patient Guardian Signature

Date

Wanda G. Smith, D.D.S.
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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient printed name _____

Patient signature _____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released (name(s) or class(es) of recipients):
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____

Wanda G. Smith, D.D.S.