The Art of Smiles
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Welcome to our office

ABOUT YOU

Today's Date ___/___/_____

Name _____ Prefer to be called _____

Last First MI Minor Single

Birth date ___/___/_____ Age _____ Male Female SS#_____ Married Separated

Mailing Address _____ City_____ State_____ Zip _____

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

Email Address _____ Preferred method of contact _____

Employer _____ Occupation _____

Employer Address _____ City_____ State _____ Zip _____

Other family members seen by us: _____

Who may we thank for referring you? _____

In the event of an emergency:

Whom should we contact? _____ Relation _____

Home Phone# (_____)_____ Cell Phone# (_____)_____

Name of your medical doctor _____ Phone # (_____)_____

PRIMARY DENTAL INSURANCE

Company Name_____ Phone# (_____)_____ Group# _____

Insured's Name _____ Insured's ID#_____ Birth date ___/___/_____

Relation to Patient _____ Employer _____

SECONDARY DENTAL INSURANCE

Company Name_____ Phone# (_____)_____ Group# _____

Insured's Name _____ Insured's ID#_____ Birth date ___/___/_____

Relation to Patient _____ Employer _____

****A note regarding dental insurance:** Some insurance companies may require some dental claims to be sent to your medical insurance provider first. Unfortunately, we do not have the capability to bill any dental insurance claims to your medical insurance provider. If this is the case, you will be required to pay the full amount for your procedure and we can give you a detailed receipt of your procedure to send to your medical insurance company for reimbursement. We apologize for any inconvenience this may cause.

FOR OFFICE USE ONLY

Have there been any changes in your health? Y N If so please list: _____

Patient Signature _____ Date _____

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Patient Signature _____ Date _____

DENTAL INFORMATION

Reason for today's visit: Exam Cleaning Emergency Consultation

Are you in pain? Yes No If yes, where and for how long? _____

Please indicate if you experience any of the following:

Bad breath	Food collecting between teeth	Sensitivity to cold
Bleeding gums	Grinding or clenching teeth	Sensitivity to hot
Clicking or popping jaw	Loose teeth	Sores or growths in mouth

How often to you brush? _____ Floss? _____

Previous Dentist _____ Date of last exam ___/___/_____ Date of last xrays ___/___/_____

Have you had deep scaling and root planing? YES NO DON'T KNOW

Were you on an active periomaintenance program? YES NO DON'T KNOW

MEDICAL HISTORY

Do you have, or have you had any of the following:

Y N AIDS/HIV Positive	Y N Eating disorder	Y N Mitral valve prolapse
Y N Anemia	Y N Epilepsy	Y N Nervousness
Y N Arthritis/Rheumatism	Y N Fainting	Y N Pacemaker
Y N Artificial valves	Y N Headaches	Y N Psychiatric care
Y N Artificial joints	Y N Heart murmur	Y N Rheumatic fever
Y N Asthma	Y N Heart problems	Y N Scarlet fever
Y N Back problems	Y N Hemophilia	Y N Stroke
Y N Cancer	Y N Herpes	Y N Surgical implant
Y N Chemical dependency	Y N Hepatitis	Y N Thyroid disease
Y N Chemotherapy	Y N High blood pressure	Y N Tobacco habit
Y N Chronic sinus infection	Y N Jaw pain	Y N Tonsillitis
Y N Cortisone treatment	Y N Kidney disease	Y N Tuberculosis
Y N Cough	Y N Liver disease	Y N Ulcer
Y N Diabetes	Y N Low blood pressure	

Please list any medications you are currently taking. _____

_____

Are you allergic to any of the following: Latex Penicillin/Amoxicillin Local anesthetics

Aspirin Sulfa drugs Codeine Ibuprofen Acetaminophen Naproxen

Any others _____

Women: Are you pregnant? _____ Nursing? _____ Taking oral contraceptives? _____

Please list any other medical concerns. _____

****I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I am responsible for reporting any changes to my dentist.**

****I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature _____ **Date**_____

*If patient is under the age of 18, this form must be signed by a parent or guardian.