PATIENT INFORMATION
SMILE 4 LIFE, P.C.

PATIENT:

NAME:_____ HOME PHONE:_____ CELL:_____

ADDRESS:_____ CITY:_____ STATE: _____ ZIP:_____

SOCIAL SECURITY #:_____ BIRTH: ____/____/_____ EMPLOYER:_____

EMPLOYER ADDRESS:_____ CITY:_____ STATE: _____ ZIP:_____

E-MAIL ADDRESS:_____ BUSINESS PHONE:_____

*IF MINOR, PARTY RESPONSIBLE FOR PAYMENT:_____ SCHOOL:_____

REFERRED BY:_____

SPOUSE/PARENT:

NAME:_____ EMPLOYER:_____

BUSINESS PHONE:_____ EXT:_____

EMPLOYER ADDRESS:_____ CITY:_____ STATE: _____ ZIP:_____

OCCUPATION:_____ YRS. WITH FIRM:_____

INSURANCE:

NAME OF POLICY HOLDER:_____

POLICY HOLDER'S BIRTH DATE: ____ /____ /_____ SOCIAL SECURITY #:_____

NAME OF DENTAL INSURANCE COMPANY:_____ GROUP #:_____

ADDRESS:_____ PHONE #:_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:_____

IS THERE SECONDARY OR DUAL COVERAGE: **YES** | **NO** COMPANY NAME:_____

POLICY HOLDER:_____

POLICY HOLDER'S BIRTH DATE: ____/____/_____ SOCIAL SECURITY #:_____

TREATMENT AUTHORIZATION AND CONSENT

I consent to treatment as necessary or desirable for the diagnosis and treatment of dental disease, deformities, or treatment of a dental emergency including X-rays, models, medication, and other therapies. This authorization and consent for treatment will be made verbally after having a full explanation of the proposed treatment, alternatives and risks. I understand that by the very nature of the proposed treatments and the uniqueness of myself as an individual that no one can predict the certainty of any outcome or success and that even in the event of treatment, my condition may worsen. I understand that no guarantee or assurances will be given to me for proposed treatment or alternatives.

I will feel free to ask questions about any proposed treatment, alternatives, and risks. I agree to abide by doctor's or hygienist's post- operative instructions and understand that my failure to care for my oral health may lead to failure of treatment.

I understand that local anesthetics embody certain risks and I will discuss with the hygienist or doctor my medical and health history indicating any serious problems and promise to inform the hygienist, doctor and staff if any changes in my medical history occur.

Signed:_____ Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain:_____
Have you ever been hospitalized or had a major surgery? ○ Yes ○ No If yes, please explain:_____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain:_____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain:_____
Do you take, or have you taken, Phen Fen or Redux? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No _____
Do you use tobacco? ○ Yes ○ No _____
Do you use controlled substances? ○ Yes ○ No _____

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking Oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain:_____

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

AIDS/HIV Positive	○Yes○No	Cortisone Medicine	○Yes○No	Hemophilia	○Yes○No	Renal Dialysis	○Yes○No
Alzheimer's disease	○Yes○No	Diabetes	○Yes○No	Hepatitis	○Yes○No	Rheumatic Fever	○Yes○No
Anaphylaxis	○Yes○No	Drug Addiction	○Yes○No	Hepatitis B or C	○Yes○No	Rheumatism	○Yes○No
Anemia	○Yes○No	Easily Winded	○Yes○No	Herpes	○Yes○No	Scarlet Fever	○Yes○No
Angina	○Yes○No	Emphysema	○Yes○No	High Blood Pressure	○Yes○No	Shingles	○Yes○No
Arthritis/Gout	○Yes○No	Epilepsy or Seizures	○Yes○No	Hives or Rash	○Yes○No	Sickle Cell Disease	○Yes○No
Artificial Heart Valve	○Yes○No	Excessive Bleeding	○Yes○No	Hypoglycemia	○Yes○No	Sinus Trouble	○Yes○No
Artificial Joint	○Yes○No	Excessive Thirst	○Yes○No	Irregular Heartbeat	○Yes○No	Spina Bifida	○Yes○No
Asthma	○Yes○No	Fainting Spells/Dizziness	○Yes○No	Kidney Problems	○Yes○No	Stomach/Intestinal Disease	○Yes○No
Blood Disease	○Yes○No	Frequent Cough	○Yes○No	Leukemia	○Yes○No	Stroke	○Yes○No
Blood Transfusion	○Yes○No	Frequent Diarrhea	○Yes○No	Liver Disease	○Yes○No	Swelling of Limbs	○Yes○No
Breathing Problem	○Yes○No	Frequent Headaches	○Yes○No	Low Blood Pressure	○Yes○No	Thyroid Disease	○Yes○No
Bruised Easily	○Yes○No	Genital Herpes	○Yes○No	Lung Disease	○Yes○No	Tonsillitis	○Yes○No
Cancer	○Yes○No	Glaucoma	○Yes○No	Mitral Valve Prolapse	○Yes○No	Tuberculosis	○Yes○No
Chemotherapy	○Yes○No	Hay Fever	○Yes○No	Pain in Jaw Joints	○Yes○No	Tumor or Growths	○Yes○No
Chest Pains	○Yes○No	Heart Attack/Failure	○Yes○No	Parathyroid Care	○Yes○No	Ulcers	○Yes○No
Cold Sores/Fever Blisters	○Yes○No	Heart Murmur	○Yes○No	Psychiatric Care	○Yes○No	Venereal Disease	○Yes○No
Congenital Heart Disorder	○Yes○No	Heart Pace Maker	○Yes○No	Radiation Treatments	○Yes○No	Yellow Jaundice	○Yes○No
Convulsions	○Yes○No	Heart Trouble/Disease	○Yes○No	Recent Weight Loss	○Yes○No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain:_____

Comments:_____

_____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parent, or Guardian:_____ Date:_____