

Patient Information



Date: _____

Daytime Phone (____) _____ Cell Phone (____) _____

Full Name _____ Birthdate _____

Address _____ SS# _____

City _____ State _____ Zip _____

Northern Address _____ In Florida how many months? _____

Sex: Male Female Married Widowed Single Child

Patient Employer _____ Employer Phone: (____) _____

Whom may we thank for referring you? _____

Are any of your family members already patient's here? Yes No

If yes, name of family member _____

Payment Method? Cash Check Credit Card Care Credit

In case of an emergency who should be notified? _____

Emergency Contact Person's Phone Number (____) _____

Primary Insurance

Person Responsible for Account Last Name _____ First Name _____ M.I. _____

Relation to Patient _____ DOB _____ SS# _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional/ Secondary Insurance

Is patient covered by additional dental insurance? Yes No

Medical History



Patient's Name _____

Physician's Name _____

Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No

If yes, describe _____

Have you ever had a blood transfusion? Yes No

If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have or have had any of these conditions :

- | | | | |
|-------------------------|---------------------|-----------------------|----------------------------------|
| Anemia | Cortisone Treatment | Hepatitis | Scarlet Fever |
| Arthritis, Rheumatism | Cough, Persistent | High Blood Pressure | Shortness of Breath |
| Artificial Heart Valves | Cough up Blood | HIV/AIDS | Skin Rash |
| Artificial Joints | Diabetes | Jaw Pain | Stroke |
| Asthma | Epilepsy | Kidney Disease | Thyroid Problems |
| Back Problems | Fainting | Liver Disease | Tobacco Habit |
| Blood Disease | Glaucoma | Mitral Valve Prolapse | Tonsillitis |
| Cancer | Headaches | Pacemaker | Tuberculosis |
| Chemical Dependency | Heart Murmur | Radiation Treatment | Ulcer |
| Chemotherapy | Heart Problems | Respiratory Disease | Venereal Disease |
| Circulatory Problems | Hemophilia | Rheumatic Fever | Congenital Cardiac Malformations |
| Osteoporosis | | | |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

Doctor's Signature _____ Date _____

Smile Evaluation

By filling out this Smile Evaluation, our team will be able to help you obtain the smile you have always wanted. Please feel free to discuss with our staff any questions or areas of concern. This allows our practice to maintain our focus and time spent on the delivery of the best quality of dental care.



Name: _____

Date: _____

Are you pleased with the appearance of you teeth when you smile?	Yes	No
Are you pleased with the color of your teeth?	Yes	No
Are you pleased with the shape of your teeth?	Yes	No
Are you pleased with the appearance of your gums when you smile?	Yes	No
Are your gums puffy, red or swollen looking? Do they bleed easily?	Yes	No
Do your old fillings still please you?	Yes	No
Are your teeth:		
Chipped?	Yes	No
Protruding?	Yes	No
Crowded?	Yes	No

If you would like to change anything about the appearance of you smile what would that be?

Check if you have problems with any of the following:

- | | | |
|-------------------------------|--------------------------------|-------------------------|
| Bad Breath | Sores or growths in mouth | Sensitivity to hot |
| Bleeding gums | Loose teeth or broken fillings | Sensitivity to sweets |
| Clicking or popping jaw | Periodontal treatment | Sensitivity when biting |
| Food collection between teeth | Grinding teeth | Sensitivity to cold |



**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

A copy of our Notice of Privacy Practices is available upon request.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, and either, have read or declined to read them.

This form will remain in my patient chart.

Print Name

Date

Signature