Smyrna
FAMILY DENTISTRY

PATIENT INFORMATION

DATE_____

PATIENT NAME_____BIRTHDATE_____M/F_____SS#_____
LAST FIRST INITIAL

ADDRESS_____CITY_____STATE_____ZIP_____

EMAIL_____PHONE(H)_____(W)_____(C)_____

OCCUPATION _____ EMPLOYER_____SINGLE/MARRIED_____

SPOUSE/PARENTS NAME_____EMPLOYER_____CONTACT PHONE._____

WILL YOU BE USING INSURANCE? _____ IF YES, PLEASE PROVIDE CARD TO FRONT DESK RECEPTIONIST.

PERSON FINANCIALLY RESPONSIBLE_____

RELATIONSHIP TO YOU_____ SSN._____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHOM SHOULD WE NOTIFY IN CASE OF EMERGENCY, OTHER THAN SPOUSE?_____ PHONE NO. _____

MEDICAL HISTORY_____

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE PAST 2 YEARS? _____ IF YES, EXPLAIN _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS? _____ IF YES, EXPLAIN_____

HAVE YOU EVER HAD EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? _____ IF YES, EXPLAIN _____

ARE YOU TAKING ANY MEDICATION, PILLS, OR DRUGS? _____ IF SO PLEASE LIST_____

_____

WOMEN: ARE YOU PREGNANT? _____ ARE YOU NURSING? _____ DO YOU TAKE BIRTH CONTROL?_____

DO YOU NOW, OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ BLOOD DISEASE
- ☐ DIABETES
- ☐ STROKE
- ☐ HEPATITIS
- ☐ EPILEPSY/ SEIZURES
- ☐ PSYCHIATRIC TREATMENT
- ☐ ARTHRITIS
- ☐ THYROID DISEASE
- ☐ OSTEOPOROSIS
- ☐ LUNG DISEASE
- ☐ RADIATION TREATMENT
- ☐ LIVER DISEASE
- ☐ KIDNEY DISEASE
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ HIV POSITIVE
- ☐ CANCER TREATMENT
- ☐ ORGAN TRANSPLANT
- ☐ ARTIFICIAL JOINTS
- ☐ FAINTING OR DIZZINESS
- ☐ STOMACH DISORDER
- ☐ GLAUCOMA
- ☐ HEART VALVE REPLACEMENT

HAVE YOU HAD ANY OTHER SERIOUS ILLNESS? _____ IF YES, LIST _____

HAVE YOU HAD AN ALLERGIC OR ADVERSE REACTION TO ANY OF THE FOLLOWING? : ☐ YES☐ NO

- ☐ PENICILLIN
- ☐ SULFA
- ☐ LOCAL ANESTHETICS
- ☐ METALS
- ☐ LATEX
- ☐ OTHER MEDICATIONS
- ☐ OTHER

ARE YOU TAKING OR HAVE YOU EVER TAKEN MEDICATION FOR OSTEOPOROSIS, MULTIPLE MYELOMA, OR OTHER CANCERS?
☐ YES☐ NO

- ☐ RECLAST
- ☐ FOSAMAX
- ☐ ACTONEL
- ☐ BONIVA
- ☐ AREDIA
- ☐ ZOMETA

HAVE YOU HAD PROBLEMS WITH DENTAL TREATMENT IN THE PAST?___ IF YES, EXPLAIN_____

CONSENT FOR SERVICES_____

I affirm the above answers are correct to the best of my knowledge. I understand the importance of a truthful and complete health history to assist my dentist in providing the best possible care. I consent to whatever dental procedures and anesthetics are necessary for the agreed treatment of the above-named patient.

I also agree to assume full financial responsibility for all treatment at time services are rendered, unless special financial arrangements are made with the front office. Our office will do the courtesy of filing for dental benefits and taking payment within 60 days. Patient portion is due on day of services. After 60 days, if no dental benefits are received, the remaining balance is the full responsibility of the guarantor.

We reserve appointment time to properly serve you and other patients. If you are not able to keep your appointment, please contact our office immediately. This advanced notice allows us the opportunity to serve other patients by placing them into the time slot. Thank you.

There will be a $50 charge for all broken appointments, unless we are given 24 hours advanced notice.

Signature_____

Date_____