PATIENT HISTORY

Today's Date _____

Name _____

Birth Date_____ Age _____ F___ M___

Marital Status _____ SS# _____

Home Address _____

City _____ ST_____ Zip _____

How Long? _____

Home Phone _____ Business Phone _____

Cell Phone _____ Email _____

Employer _____

Position _____ How Long? _____

Employer Address _____

_____

Name of Spouse_____

Spouse's SS# _____

Spouse's Employer_____

Position _____ How Long? _____

Spouse's Employer Address _____

_____

Phone _____

Name of Nearest Relative Not Living With You _____

_____

Phone _____

Whom may we thank for referring you? _____

THIS ACCOUNT WILL BE PAID BY

❑ CASH ❑ CHECK ❑ CREDIT CARD

❑ DEBIT CARD (PATIENT LIABILITY)

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name_____

SS# _____

Birth Date_____ Age _____ F___ M___

Address _____

City _____ST _____ Zip _____

Phone _____

Responsible Party's Employer _____

Position _____ How Long? _____

Employer's Address _____

Employer's Phone_____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____

Birth Date _____SS# _____

Subscriber's Employer _____

Employer's Address _____

Insurance Company _____

Address _____

Group No. _____

Have you used the dental insurance previously? ❑ Y ❑ N

SECONDARY INSURANCE INFORMATION

Subscriber's Name _____

Birth Date _____SS# _____

Subscriber's Employer _____

Address _____ Phone _____

Insurance Co. _____

Address _____

Group No. _____

I authorize all of the above information to be used as needed by the dental office to facilitate my dental treatment. I agree to assume the financial responsibility for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGN_____**DATE** _____

RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS

I, _____ hereby assign all dental benefits to Smith-Brauer Dentistry I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGN_____**DATE** _____

HEALTH HISTORY

General Health (Please Check): ❑ Good ❑ Fair ❑ Poor

Physician _____ Phone _____

Address_____

Are you presently taking any medicine or drugs? ❑ Y ❑ N

If yes, list drug, dosage, and frequency _____

_____

Allergic to Penicillin or any other drug? ❑ Y ❑ N

If yes, explain_____

_____

Ever been hospitalized in the past 5 years? ❑ Y ❑ N

Have any excessive bleeding when cut? ❑ Y ❑ N

(Women) Are you pregnant? ❑ Y ❑ N

If yes, how long? _____

(Women) Are you taking oral contraceptives? ❑ Y ❑ N

If yes, did you know that antibiotics can decrease the effectiveness of birth control pills? ❑ Y ❑ N

Circle any of the following you have had or have presently:

- ❑ Heart Condition
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Chest Pains (Angina)
- ❑ Heart Surgery
- ❑ Abnormal Blood Pressure
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Anemia or Hemophilia
- ❑ Bruise Easily
- ❑ Shortness of Breath
- ❑ Swelling of the Ankles
- ❑ Lung Disease
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Ulcers
- ❑ Skin Rashes or Hives
- ❑ Kidney Trouble
- ❑ Diabetes
- ❑ Sickle Cell Disease
- ❑ Liver Disease
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Yellow Jaundice
- ❑ Thyroid Disease
- ❑ Cortisone Medicine
- ❑ Glaucoma
- ❑ Arthritis or Rheumatism
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Cancer or Tumor
- ❑ Venereal Diseases
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ HIV Positive/AIDS
- ❑ Genital Herpes
- ❑ Cold Sores
- ❑ Epilepsy or Seizures
- ❑ Psychiatric Treatment
- ❑ Artificial Joint
- ❑ Artificial Implants

DENTAL HISTORY

Date of last visit to a dentist _____

Dentist's name _____ Phone _____

Did you have x-rays taken? ❑ Y ❑ N

Have you had all your teeth x-rayed in the past 3 years? ❑ Y ❑ N

Do you wear full or partial dentures? ❑ Y ❑ N

If yes, how old are they? _____

Does any member of your family, including your parents, wear dentures? ❑ Y ❑ N

Have you had orthodontic treatment? ❑ Y ❑ N

Do you clench or grind your teeth during the day or night? ❑ Y ❑ N

Have you ever had pain in your jaw joint or your face (in or about your face)? ❑ Y ❑ N

Orthodontic appliances worn now or ever before? ❑ Y ❑ N

Does your jaw joint click or do you have difficulty opening your mouth widely? ❑ Y ❑ N

Do you have an unpleasant odor, or taste, in your mouth? ❑ Y ❑ N

Do your gums bleed when brushing? ❑ Y ❑ N

Have you had gum disease or pyorrhea? ❑ Y ❑ N

Is your mouth or teeth sensitive to:
Pressure: ❑ Y ❑ N Cold: ❑ Y ❑ N Hot: ❑ Y ❑ N

Do you or any member of your family snore? ❑ Y ❑ N

Does food catch between your teeth every time you eat? ❑ Y ❑ N

Are you dissatisfied with the appearance of your teeth? ❑ Y ❑ N

How can we help? _____

What is the main reason for your visit today? _____

_____

Please add anything you feel is important for the doctor to know: _____

_____

_____