Smith & Rockefeller FAMILY AND COSMETIC DENTISTRY

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PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____

Birthdate: _____ Social Security #: _____ Driver's Lic #: _____
If you do not provide your SS#, you will need to file your claims.

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Employer: _____

Spouse's Name: _____ Birthdate: _____ SS#: _____

Spouse's Occupation: _____ Spouse's Employer: _____

If patient is a minor, give parent's name or guardian's name: _____

List other "immediate family members" who are patients in our office: _____

Who is responsible for your account? _____

Whom may we thank for referring you to our office: _____

PHONE NUMBERS AND CONTACTS

Home Phone: _____ Work Phone: _____ Ext: _____

Fax: _____ Cell Phone: _____

Email: _____ Spouse's Work Phone: _____

Best time/place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work phone: _____

Address: _____

DENTAL INFORMATION

Are your teeth sensitive to heat or cold? ☐ Yes ☐ No Pressure? ☐ Yes ☐ No Sweets? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No Do your gums bleed when you brush? ☐ Yes ☐ No

Do you have any fear of dental work? ☐ Yes ☐ No

Date of last dental examination: _____ What was done at that time? _____

How would you describe your current dental problems? _____

How do you feel about the appearance of your teeth? _____

Name of previous dentist: _____ Phone: _____

Month and year of your last professional cleaning _____ Do you have recent x-rays? ☐ Yes ☐ No

MEDICAL INFORMATION

1. Are you having pain or discomfort at this time? . . . . . Yes☐ No☐
2. Have you been a patient in the hospital during the past two years? . . . . . Yes☐ No☐
3. Have you been under the care of a medical doctor during the past two years? . . . . . Yes☐ No☐
   Physician's Name: _____ Phone #: _____
   Address: _____
4. Have you taken medications or drugs during the past two years? . . . . . Yes☐ No☐
5. Are you now taking any medications or drugs? . . . . . Yes☐ No☐
   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics?
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Check Yes or No to each item:

Heart Failure	Yes☐ No☐	Artificial Joints (hip, knee, etc.)	Yes☐ No☐	Hepatitis B (serum)	Yes☐ No☐
Heart Disease or Attack	Yes☐ No☐	Kidney Trouble	Yes☐ No☐	Hepatitis C	Yes☐ No☐
Angina Pectoris	Yes☐ No☐	Ulcers	Yes☐ No☐	STD/STI	Yes☐ No☐
Congenital Heart Disease	Yes☐ No☐	Diabetes	Yes☐ No☐	AIDS	Yes☐ No☐
Heart Murmur	Yes☐ No☐	Hypoglycemia	Yes☐ No☐	HIV Positive	Yes☐ No☐
High Blood Pressure	Yes☐ No☐	Thyroid Problems	Yes☐ No☐	Cold Sores/Fever Blisters	Yes☐ No☐
High Cholesterol	Yes☐ No☐	Glaucoma	Yes☐ No☐	Blood Transfusion	Yes☐ No☐
Arteriosclerosis	Yes☐ No☐	Cancer	Yes☐ No☐	Hemophilia	Yes☐ No☐
Mitral Valve Prolapse	Yes☐ No☐	Chemotherapy	Yes☐ No☐	Anemia	Yes☐ No☐
Artificial Heart Valve	Yes☐ No☐	Radiation Therapy	Yes☐ No☐	Sickle Cell Disease	Yes☐ No☐
Heart Pacemaker	Yes☐ No☐	Emphysema	Yes☐ No☐	Bruise Easily	Yes☐ No☐
Heart Surgery	Yes☐ No☐	Chronic Cough	Yes☐ No☐	Liver Disease	Yes☐ No☐
Rheumatic Fever	Yes☐ No☐	Tuberculosis	Yes☐ No☐	Yellow Jaundice	Yes☐ No☐
Arthritis	Yes☐ No☐	Asthma	Yes☐ No☐	Epilepsy or Seizures	Yes☐ No☐
Rheumatism	Yes☐ No☐	Hay Fever	Yes☐ No☐	Fainting or Dizzy Spells	Yes☐ No☐
Cortisone Medicine	Yes☐ No☐	Allergies or Hives	Yes☐ No☐	Nervousness	Yes☐ No☐
Drug Addiction	Yes☐ No☐	Sinus Trouble	Yes☐ No☐	Tumors	Yes☐ No☐
Stroke	Yes☐ No☐	Hepatitis A (infectious)	Yes☐ No☐	Developmentally Disabled	Yes☐ No☐

8. When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? . . . . . Yes☐ No☐
9. Do your ankles swell during the day? . . . . . Yes☐ No☐
10. Do you use more than two pillows to sleep? . . . . . Yes☐ No☐
11. Have you lost or gained more than 10 pounds this past year? . . . . . Yes☐ No☐
12. Do you ever wake up from sleep and feel short of breath? . . . . . Yes☐ No☐
13. Are you on a special diet? . . . . . Yes☐ No☐
14. Do you have or have you had any disease, condition or problem not listed? . . . . . Yes☐ No☐
    If yes, please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature X: _____ Date: _____

FOR WOMEN ONLY:
Are you pregnant? Yes☐ What Month? _____ No☐ Are you nursing? Yes☐ No☐ Are you taking birth control pills? Yes☐ No☐

CONSENT:

1. The undersigned hereby authorizes the doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the treating doctor(s) and to the use of appropriate medication and therapy indicated for sure treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit prior to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the times services are rendered unless prior financial arrangements have been made. I understand that a 12% APR monthly finance charge may be added to my account for all charges 90 days and older. In the event monthly payments are not received by the agreed upon date for payment plans, I understand that a late fee may be added to my account in addition to finance charges.
4. If I have insurance and wish for this office to file my claims, I understand that I am responsible for seeing that my insurance carrier pays within 45 days or I will be responsible for the unpaid balance on my account. I know that any unpaid balance by my insurance carrier is my responsibility. I understand I am responsible for knowing the terms and limitations on my insurance policy in order to inform this office as to what my plan will pay. I know this office has no connection with my insurance company and that I am to keep this office informed of any kind of changes in my policy or carrier. I realize my claims are being filed electronically as a courtesy and that I must pay the patient portion at each visit. If I receive payment from the insurance company, I will forward payment in full immediately to this office. I, the undersigned, certify that I and/or my dependents have insurance coverage and I assign all benefits, if any, directly to this office. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize my signature to be kept on file and used on all insurance submissions:

Subscriber's Signature X: _____ Date: _____

5. In the event of default of payment, I understand a reasonable collection fee and/or attorney fee may be added to my account balance in an attempt to collect the amount of my unpaid account balance. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise this office of any changes in the information contained on this form.

Patient Signature X: _____ Date: _____ Witness: _____

Parent/Responsible Party Signature X: _____ Date: _____ Relation to Patient: _____

FOR OFFICE USE: Reviewed by Doctor _____ Date: _____