SMILES DENTAL | FAMILY DENTISTRY

HEALTH HISTORY

NAME: _____ **DATE:** _____

DENTAL HISTORY

Do you have or have you had the following? (Please circle yes or no to all that apply to you).

Bleeding Gums	Yes	No	Periodontal treatment	Yes	No
Broken Fillings	Yes	No	Painful or locking jaw	Yes	No
Chronic bad breath	Yes	No	Sensitive teeth	Yes	No
Decay teeth	Yes	No	Sores or areas of swelling	Yes	No
Food catching between teeth	Yes	No	Injury to teeth or jaw	Yes	No
Grinding or clenching of teeth	Yes	No	Dizziness	Yes	No
Loose teeth	Yes	No	Happy with smile	Yes	No
Orthodontic treatment	Yes	No			

MEDICAL HISTORY

Physicians name: _____

Telephone #: _____

Do you have or have you had the following? (Please circle yes or no to all that apply to you)

Anemia	Yes	No	Hemophilia	Yes	No
Arthritis, rheumatism	Yes	No	Hepatitis/ liver disease	Yes	No
Artificial heart valves	Yes	No	High or low blood pressure	Yes	No
Artificial joints	Yes	No	HIV positive/ AIDS	Yes	No
Asthma	Yes	No	Kidney disease	Yes	No
Autoimmune disease	Yes	No	Mitral valve prolapse	Yes	No
Back problems	Yes	No	Malignancy or tumor/cyst	Yes	No
Blood disease	Yes	No	Nervous disorders	Yes	No
Abnormal bleeding	Yes	No	Pacemaker	Yes	No
Bruising easily	Yes	No	Psychiatric care	Yes	No
Cancer	Yes	No	Radiation treatment	Yes	No
Chemical dependency	Yes	No	Respiratory disease	Yes	No
Chemotherapy	Yes	No	Rheumatic fever/rheumatic heart disease	Yes	No
Cortisone treatment/steroids	Yes	No	Sinus problems	Yes	No
Circulatory problems	Yes	No	Shortness of breath	Yes	No
Persistent,chronic or Bloody Cough	Yes	No	Stomach/digestive system problems	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Epilepsy/ Seizures	Yes	No	Thyroid disease	Yes	No
Eye disorder	Yes	No	Tobacco habit	Yes	No
Headaches	Yes	No	Tuberculosis	Yes	No
Heart murmur	Yes	No	Venereal disease	Yes	No
Heart disease	Yes	No			

WOMEN:

Are you pregnant	Yes	No
Are you nursing	Yes	No
Are you taking birth control	Yes	No

****PLEASE LIST RECENT HOSPITALIZATIONS, MEDICATIONS, and ALLERGIES**:_____

_____

_____

ALL: Do you have or have had any other conditions or problems NOT listed Yes No

If yes, _____

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PATIENT CONTACT & INSURANCE INFO

Patients name (Print):_____**DOB:**_____
If patient is a child parent's name:_____
Address:_____
Apt#:_____City::_____State:_____Zip:_____
Home phone:_____Cell phone_____
Business phone:_____Email:_____
Single_____ Married_____ Separated_____Divorced_____Widowed_____
Name of spouse:_____
***Emergency contact:**_____Phone#:_____

Primary insurance:
Subscriber Name: _____ Subscriber DOB: _____
Subscriber ID & Social Security # :_____& _____
Name of employer: _____Group #:_____
Employer address:_____
Dental Insurance Company: _____Phone #:_____

If any secondary dental insurance:
Subscriber Name: _____Subscriber DOB: _____
Subscriber ID & Social Security # :_____& _____
Name of employer: _____Group #:_____
Employer address:_____
Dental Insurance Company: _____Phone #:_____

How did you find us?

_____

FOR EVERY NEW PATIENT YOU REFER TO OUR OFFICE, BOTH YOU AND YOUR REFERRAL WILL RECEIVE A $20 CREDIT TOWARDS YOUR ACCOUNT.

Patients/Guardian Signature:_____ **Date**:_____

CREDIT CARD AUTHORIZATION FORM

I _____, authorize **Q Smiles Dental** to charge the credit card below. **Only to be used on agreed upon purchases**. I understand that my information will be saved to file for future transactions on my account.

Card Type: (Please Check One)

___Visa ___Mastercard ___AMEX ___Discover ___ CareCredit

Cardholder Name (as shown on card)**:**_____

Card Number:_____

Expiration Date (MM/YY)**:**_____ **CVC Code:**_____

Cardholder Zip Code (from credit card billing address):_____

Guarantors Cell Phone Number:_____

_____ _____

Customer Signature **Date**