WELCOME

Patient Information

Full Name ______________________________

Date ____________ ID#/SS#______________

Address ________________________________

City ______________ State _____ Zip ______

Sex: ☐M ☐F Age __ Birthdate __/__/__ (MM/DD/YY)

Marital Status __________________________

Occupation _____________________________

Employer ______________________________

Employer's Address ______________________

Employer's Phone (___)_________________

Spouse/Partner's Name ___________________

If your spouse or partner provides your insurance, please fill out the following info about him or her:

Birthdate __/__/__ (MM/DD/YY) SS# _______________

Employer _______________________________

Whom may we thank for referring you?

____

Dental Insurance Info

Who is responsible for this account? ___________

Relationship to Patient _______________________

Insurance Company ___________________________

Group # _______________ SS# _________________

Do you have secondary coverage? ☐YES ☐NO

Subscriber's Name ____________________________

Relationship to Patient _______________________

Insurance Company ___________________________

Group # _______________ SS# _________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to **Open Smile Dental** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party's Signature

____
Relationship to Patient — Date Signed

Contact Information

Home Phone (____)___________ Work (____)__________ ext_____ Cell (____)___________

Best place and time to reach you? ____

Email ____________________________ Spouse/Partner's phone (optional) (____)___________

IN CASE OF EMERGENCY, CONTACT (name at least one person not in your household):

Name _____________ Relationship __________ Phone #s (____)___________ / (____)__________

Name _____________ Relationship __________ Phone #s (____)___________ / (____)__________

Dental History

Reason for today's visit _____________

____

Former Dentist ____________________

City / State _______________________

Date of last visit __________________

Date of last X-Rays ________________

Please check "yes" or "no" to indicate if you have had any of the following.

	Y	N
Bad breath	☐	☐
Bleeding gums	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette/pipe/cigar smoking	☐	☐
Clicking or popping jaw	☐	☐
Dry mouth	☐	☐
Fingernail biting	☐	☐
Food collection between teeth	☐	☐
Grinding teeth	☐	☐
Swollen or tender gums	☐	☐
Jaw pain or tiredness	☐	☐
Lip or cheek biting	☐	☐
Loose teeth	☐	☐
Broken fillings	☐	☐
Mouth breathing	☐	☐
Mouth pain while brushing	☐	☐
Orthodontic treatment	☐	☐
Pain around ear	☐	☐
Periodontal treatment	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐
Sensitivity when biting	☐	☐
Sores or growths in mouth	☐	☐

How often do you floss? ___________

How often do you brush? ___________

Health History

Physician's Name ________________________ Date of last visit ___________

Please indicate whether or not you have or have had any of the following.

	Y	N		Y	N		Y	N
AIDS/HIV	☐	☐	Emphysema	☐	☐	Psychiatric care	☐	☐
Anemia	☐	☐	Epilepsy	☐	☐	Radiation treatment	☐	☐
Arthritis/Rheumatism	☐	☐	Fainting or dizziness	☐	☐	Respiratory Disease	☐	☐
Artificial heart valves	☐	☐	Glaucoma	☐	☐	Rheumatic Fever	☐	☐
Artificial joints	☐	☐	Headaches	☐	☐	Scarlet Fever	☐	☐
Asthma	☐	☐	Heart murmur	☐	☐	Shortness of breath	☐	☐
Back problems	☐	☐	Heart problems	☐	☐	Sinus trouble	☐	☐
Bleeding abnormally with			Hepatitis Type _____	☐	☐	Skin rash	☐	☐
extractions or surgery	☐	☐	Herpes	☐	☐	Special diet	☐	☐
Blood Disease	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Swollen feet or ankles	☐	☐
Chemical Dependency	☐	☐	Jaw pain	☐	☐	Swollen neck glands	☐	☐
Chemotherapy	☐	☐	Kidney Disease	☐	☐	Thyroid problems	☐	☐
Circulatory problems	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Congenital heart lesions	☐	☐	Low blood pressure	☐	☐	Tumor/growth in head/neck	☐	☐
Cortisone treatments	☐	☐	Mitral valve prolapse	☐	☐	Ulcer	☐	☐
Cough, persistent or bloody	☐	☐	Nervous system problems	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Weight loss, unexplained	☐	☐

Do you wear contact lenses? ☐ ☐

WOMEN:

Are you pregnant? ☐ ☐ Due Date, if yes _______________

Are you on birth control? ☐ ☐

Are you breastfeeding? ☐ ☐

Medications?

List any medications you are currently taking, and its correlating diagnosis: ___________________________

____

____

____

Pharmacy Name ___________________________

City / State ______________Phone (____)__________

Allergies?

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Other ___________________________________
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa

I certify that the information provided above is true and correct to the best of my knowledge.

Patient's Signature: _________________________________ Date: _________________

How do you feel about your smile?

	Y	N		Y	N		Y	N
I want whiter teeth	☐	☐	My teeth are uneven/crooked	☐	☐	My tooth/teeth are chipped	☐	☐
My teeth have white spots	☐	☐	Some of my teeth overlap	☐	☐	I have pointed eye-teeth	☐	☐
I grind/clench my teeth	☐	☐	I have gaps between my teeth	☐	☐	Some teeth are too big/small	☐	☐
I use a nightguard	☐	☐	I have rotated teeth	☐	☐	I want to change the shape/size	☐	☐
I have sensitive teeth	☐	☐	I want to get braces	☐	☐	of some of my teeth	☐	☐
I want my teeth to look younger	☐	☐	I have unattractive dental work (silver fillings, old crowns/bridges)	☐	☐	I need a more self-confident smile	☐	☐

If you answered "yes" to any of the above questions, we've got good news for you! You can be on your way to a brighter, whiter, more confident smile. Ask about our 12 month interest-free payment program.