Smile More Dental
Family and Cosmetic Dentistry

- **Step 1 - Patient Information**

First Name: ____________________ Last Name: ____________________ MI: ___ Date of Birth: __________

Address: ____

City: _____________________________________ State: ______ Zip: _____________

Home Phone #: _________________ Cell #: _________________ Email: ______________________________

Social Security #: ____________________ Drivers Lic #: __________________________ Sex: ☐Male ☐Female

Employer Name: ____ Employer Phone #: _______________

Emergency Contact Name: ___________________________________ Emergency Contact #: ____________

Preferred Pharmacy Name and Number: ___________________________________

- **Step 2 - Parent or Guardian (if patient is under 18 years old)**

Relationship to Patient: _________________________

First Name: ____________________ Last Name: ____________________ MI: ___ Date of Birth: __________

Address: ____

City: __________ State: _____ Zip: __________

Home Phone: _______________ Cell: _______________ Email: ______________________________

Social Security #: ____________________ Drivers Lic #: __________________________ Sex: ☐Male ☐Female

Employer Name: ____ Employer Phone #: _______________

- **Step 3 - Insurance Information (Write "None" under Name of Insured if you don't have insurance)**

Dental Insurance Information	**Medical Insurance Information**
Name Policy Holder: _________________	Name Policy Holder: _________________
Relationship to Patient: _______________________	Relationship to Patient: _______________________
Policy Holder Date of Birth: ____________________	Policy Holder Date of Birth: ____________________
Policy Holder Social Security #: __________________	Policy Holder Social Security #: __________________
Policy Holder Employer Name & Address:	Policy Holder Employer Name & Address:
____	____
____	____
Insurance Company: __________________________	Insurance Company: __________________________
Group # _______________	Group # _______________
Policy #: _______________	Policy #: _______________
Phone #: _______________	Phone #: _______________

- **Step 4 - How did you hear about us?**

☐1800Dentist ☐Mailer ☐Google ☐Friend/Family ________ ☐Dental Insurance Company ☐Other________

- **Step 5 –PLEASE FLIP THE PAGE AND COMPLETELY FILL OUT YOUR MEDICAL HISTORY**

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	◯ Yes	◯ No	If yes, please explain: ______
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, please explain: ______
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No	If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes	◯ No	______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes	◯ No	______
Are you on a special diet?	◯ Yes	◯ No	
Do you use tobacco?	◯ Yes	◯ No	
Do you use controlled substances?	◯ Yes	◯ No	

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________________

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________________

Comments: ______________________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________