Friendly Smiles Dental Group – Patient Information Form

PATIENT INFORMATION

First Name: _____ Last Name: _____ M.I. : _____

Street Address: _____

Street Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

SS #: _____ Age: _____ Birth Date: _____

Marital Status: _____ Sex: ☐ Female ☐ Male

Employers Name: _____ Occupation: _____

Business Address: _____

Business Phone: _____ Business Email: _____

Who Should We Thank For Referring You?: _____

EMERGENCY CONTACT: In the event of an emergency, please contact:

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____

PRIMARY INSURANCE INFORMATION

Person Responsible for Account

First Name: Last Name: M.I. :

Relationship to Patient: SS #:

Birth Date: Email Address:

Home Phone: Cell Phone:

(If Different From Patient)

Street Address:

City: State: Zip Code:

(Responsible Persons Information)

Employers Name: Occupation:

Business Address:

Business Phone: Business Email:

(Insurance Information)

Insurance Company Name:

Insurance Phone: Insurance Email:

Contract #: Group #: Subscriber #:

Name of Other Dependants on this Plan:

Check The Box If You Have Had Problems With Any Of The Following

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Sensativity to Cold
- ☐ Loose Teeth or Broken Fillings
- ☐ Food Collection Between Teeth
- ☐ Sensativity to Sweets
- ☐ Sensativity When Biting
- ☐ Sensativity to Hot
- ☐ Periodontal Treatment
- ☐ Grinding or Clenching Teeth
- ☐ Clicking or Popping Jaw
- ☐ Sores or Growths in Mouth

How Often Do You Brush?

How Often Do You Floss?

How Do You Feel About the Appearance of Your Teeth?

Have You Ever Experienced an Adverse Reaction During or in Conjunction with a Mediacal or Dental Proceedure? ◯ Yes ◉ No

Other Information About Your Dental Health or Previous Treatment

MEDICAL HISTORY

Physicians Name

Date of Last Visit

Physicians Phone #

Have Had Any Serious Illnesses or Operations? ◯ Yes ◯ No

If You Answered Yes to the Above Question, Please Describe

Are You Currently Under a Physicians Care? ◯ Yes ◯ No

If Yes, Please Explain

Have You Ever Had a Blood Transfusion? ◯ Yes ◯ No If Yes, Approx Date

Are You Pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking Birth Control Pills? ◯ Yes ◯ No

Please List Any Current Medications

Please List Any Drug Allergies

Check The Box If You Have Had Problems With Any Of The Following

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Skin Rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical Implants
- ☐ Back Problems
- ☐ Chemotherapy
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Cortisone Treatment
- ☐ Rapid Weight Loss or Gain
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Anemia
- ☐ Arthritis / Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Circulatory Problems
- ☐ Headaches
- ☐ Herpes
- ☐ Swollen Feet or Ankles
- ☐ Respitory Disease
- ☐ Psychiatric Care
- ☐ Rheumatic / Scarlet Fever
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Asthma
- ☐ Cancer
- ☐ Tonsillitis
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Pacemaker
- ☐ Tobacco Habit
- ☐ Ulcer / Colitis
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Liver Diseas
- ☐ Material Allergies
- ☐ Mitral Valve Prolapse
- ☐ Atopic (Allergy Prone)
- ☐ Chemical Dependency
- ☐ Food Allergies
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Tuberculosis
- Thyroid Disease
- ☐ Venereal Disease

If You Answered Yes to Any of the Questions Above, Please Explain

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges weather or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved

Please Print and bring with you to your next appointment