State Street Smiles

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

Patient Information

Check Appropriate Box:

☐ Mr. ☐ Dr. ☐ Mrs. ☐ Ms. ☐ Miss Name _____

Soc. Sec.#_____ Birth Date _____ Home Phone _____

E-mail _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Patient's Employer _____ Occupation _____ Work Phone _____

Spouse's Name _____ Employer _____ Work Phone _____

Person to Contact in Case of Emergency _____

Relationship _____ Phone _____ Cell Phone _____

If you are completing this form for another person, what is your name and relationship to that person?

_____

Whom may we thank for referring you? _____

Dental Insurance Information (Please provide information for insured party)

Name or Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Insurance ID # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group #_____ Union or Local # _____

Do you have any secondary dental insurance coverage? ☐ Yes ☐ No

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? ☐ Yes ☐ No
   If so, explain _____
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
3. Are you taking any prescription medications? ☐ Yes ☐ No
   Please list _____
   _____
   _____
4. Are you taking ASPIRIN or any other non-prescription medication on a regular basis? ☐ Yes ☐ No
   Please list _____
   _____
5. Do you use tobacco? ☐ Yes ☐ No
6. Do you use alcohol ☐ Yes ☐ No
7. Do you use cocaine or other drugs? ☐ Yes ☐ No
8. Are you wearing contact lenses? ☐ Yes ☐ No

Patient Medical History (continued)

9. Are you allergic to or have you had any reactions to:

- ☐ Nitrous oxide/laughing gas
- ☐ Latex
- ☐ Local Anesthetics (i.e. Novocaine/epinephrine)
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Sulfa Drugs
- ☐ Codeine or other narcotics
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Other _____

10. Women Only:
    a) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
    b) Are you nursing? ☐ Yes ☐ No
    c) Are you taking birth control pills? ☐ Yes ☐ No
    Note: Antibiotics counteract the effect of birth control pills. Please consult your physician.

11. Do you have or have you had any of the following?

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Anemia/Blood Disorders
- ☐ Swollen Ankles
- ☐ Fainting/Seizures
- ☐ Asthma
- ☐ Low Blood Pressure
- ☐ Epilepsy/Convulsions
- ☐ Leukemia
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ AIDS or HIV Infection
- ☐ Thyroid Problem
- ☐ Damaged Heart Valves
- ☐ Heart Disease
- ☐ Cardiac Pacemaker
- ☐ Angina
- ☐ Emphysema
- ☐ Cancer
- ☐ Arthritis
- ☐ Joint Replacement or Implants
- ☐ Hepatitis/Jaundice
- ☐ Sexually Transmitted Disease
- ☐ Stomach Troubles/ Ulcers
- ☐ Chest Pains
- ☐ Easily Winded
- ☐ Stroke
- ☐ Hay Fever/Allergies
- ☐ Tuberculosis
- ☐ Radiation Therapy
- ☐ Glaucoma
- ☐ Recent Weight Loss
- ☐ Liver Disease
- ☐ Heart Troubles
- ☐ Respiratory Problems
- ☐ Problems with Mental Health
- ☐ Other_____

12. Do you have any disease, condition or problem not listed above that you think we should know about? ☐ Yes ☐ No
    If so, explain _____

Patient Dental History

1. How do you take care of your teeth daily? _____
2. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
3. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
4. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No
5. Do you feel pain in any of your teeth? ☐ Yes ☐ No
6. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
7. Do you bite your lips or checks frequently? ☐ Yes ☐ No
8. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
9. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No
10. Have you had any orthodontic work? ☐ Yes ☐ No
11. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
12. Have you had any serious problems associated with previous dental treatments? ☐ Yes ☐ No
13. Have you ever experienced any of the following problems in your jaw?
    a) Clicking? ☐ Yes ☐ No
    b) Pain (joint, ear, side of face) ☐ Yes ☐ No
    c) Difficulty in opening or closing? ☐ Yes ☐ No
    d) Difficulty in chewing? ☐ Yes ☐ No
14. Do you have frequent headaches? ☐ Yes ☐ No
15. Do you clench or grind your teeth? ☐ Yes ☐ No
16. Are you happy with the appearance of your teeth? ☐ Yes ☐ No
    If not, explain _____
17. Is there anything you would like to improve about the appearance of your teeth or smile? ☐ Yes ☐ No
    If so, explain _____

Consent, Authorization, and Release

I certify that I have read and understand the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize the dentist or staff to perform all dental services that I or my child/dependent may need. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that it is my responsibility to know the terms of my dental insurance contract (i.e. How often my insurance carrier will pay for exams and cleanings). This consent shall remain in full force and in effect until canceled by either party.

X _____ _____

Signature of patient or parent if minor Date