NEW PATIENT INFORMATION

Welcome to THE SCIENCES OF SMILES®!
To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____

Home phone _____ Work phone _____ Mobile phone _____

Email _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

EMERGENCY CONTACT Name _____ Home/mobile phone_____

HOW DID YOU HEAR ABOUT US? ❑ Friend/Family Please tell us who so we can thank them:_____

❑ Yelp ❑ Google ❑ Facebook ❑ YouTube ❑ Other - Please explain_____

PREFERRED PHARMACY (Name/Address):_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____

Group #_____ Member #_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's Social Security number: _____ Spouse's Date of Birth_____

Dental Insurance Co._____ Group #_____ Member #_____

MEDICAL HEALTH HISTORY

Are you under a physician's care right now? ❑ yes ❑ no If yes, please explain_____

Have you ever been hospitalized or have 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 taken, or have you taken, Phen-Phen or Redux? ❑ yes ❑ no If yes, please explain_____

Are you on a special diet? ❑ yes ❑ no If yes, please explain_____

Do you smoke or use tobacco? ❑ yes ❑ no

Patient's name _____ Date of Birth _____

Do you use controlled substances? ❑ yes ❑ no

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ Pregnant/Trying to get pregnant?
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Your Primary Physician Name:_____ Phone:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that by providing incorrect information to my (or patient's) health. It is my responsibility to inform THE SCIENCE OF SMILES® about any changes to my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

DATE_____