My Smyle
Family & Cosmetic Dentistry

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. #_____
Last Name First Name M.I.

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Email _____

Sex M ☐ F ☐ Age _____ Birthdate_____ Single ☐ Married ☐ Widowed ☐ Separated ☐

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Notify in case of emergency _____ Relation to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Who may we thank for referring you to our office? _____

Primary Insurance

Policy Holder_____

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Email _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company_____ Phone _____

Contract # _____ Group #_____ Subscriber's #_____

Name(s) of other dependents under this plan _____

Medical History

Physician's name _____ Address_____ Phone _____

Physician's Email _____ Date of last visit_____

Are you under physician's care now? Y ☐ N ☐ If yes, please explain:_____

Have you ever been hospitalized or had a major operation? Y ☐ N ☐ If yes, please explain:_____

Have you ever had a serious head or neck injury? Y ☐ N ☐ If yes, please explain:_____

Are you taking any medication, pills, or drugs? Y ☐ N ☐ If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? Y ☐ N ☐

Are you on a special Diet? Y ☐ N ☐

Do you use tobacco? Y ☐ N ☐

Do you use Controlled substances? Y ☐ N ☐

Women: Are you

Pregnant? Y ☐ N ☐

Nursing? Y ☐ N ☐

Taking oral contraceptives? Y ☐ N ☐

Are you allergic to any of the following?

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

Other: _____

Are you taking any of the following medications?

Nerve pills ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐

Pain killers (including aspirin) ☐ Other: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heart Beat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/ Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/ Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/ Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumor or Growths
☐ Bruise Easily	☐ Fainting Spells/ Dizziness	☐ High Blood Pressure	☐ Renal dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Authorization

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 my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

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 whether or not paid by insurance.

Signature_____ Date_____