SelmerSmiles

Welcome to our dental office, we are so glad to have you as a patient! The benefits of a happy, healthy smile are immeasurable! It is our goal to help you reach and maintain maximum oral health. Please fill out the following forms completely. The better we communicate, the better we can care for you!

Patient Information

Patient's Name: Last_____ First_____ Middle Initial _____ Sex: M F
Birth date_____ Age_____ Social Security Number_____-_____-_____
Address_____ City_____ State_____ Zip_____
Home Phone #_____ Cell Phone #_____ Work Phone #_____
Email Address_____ Employer_____
If patient is a minor, list parent or guardian name_____ Reason for this visit_____
Who may we thank for REFERRING you to our office?_____ Today's date_____

Person Financially Responsible for Account

Name: Last_____ First_____ Middle _____Marital status_____
Residence: Street_____City_____State_____Zip_____
Mailing Address: Street _____ City_____ State_____ Zip_____
Social Security Number _____-____-_____ Birth date_____ Driver's License #_____
Relationship to patient_____ Employer_____ Occupation_____
Number of years employed_____ Home Phone #_____ Cell Phone #_____
Work Phone #_____Email Address_____

Spouse of Patient

(or spouse of person financially responsible)

Name: Last_____ First_____ MI_____ Employer_____
Number of years employed_____ Occupation_____ Social Security Number _____-____-_____
Cell Phone #_____ Work Phone #_____ Birth date _____

Emergency Information

Name_____ _____Address_____
City, State, Zip_____ Home Phone #_____ Cell Phone #_____

Primary Dental Insurance

Insured Name_____ Insurance company_____
Insurance Company Address_____ Insured Employer_____
Insured Social Security Number ____-___-____ Group Number_____ Birth date_____

Secondary Dental Insurance

Insured Name_____ Insurance company_____
Insurance Company Address_____ Insured Employer_____
Insured Social Security Number ____-___-____ Group Number_____ Birth date_____

Medical and Dental History

Do you wear dentures (partial or full)? Y N
Have you had braces (orthodontics)? Y N
Do you have bleeding gums or sensitive teeth? Y N
Do you have headaches, earaches, or neck pain? Y N
Are there any sores or any growths in your mouth now? Y N
Have you been told you have gum problems? Y N
Have you ever seen a periodontist (gum specialist)? Y N

Please List Current Medications:_____
_____
_____
_____
_____

Women: Are you pregnant? Y N
Are you breastfeeding? Y N
Are you taking oral contraceptives (birth control)? Y N

Allergies:
□ Aspirin □ Antibiotics □ Codeine □ Latex □ Local Anesthetic □ Penicillin □ Other_____

Do you have or previously had any of the following? (Please mark all that apply)

□ **Heart Problems**
- □ Abnormal Heart Conditions
- □ High Blood Pressure
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Stents/Bypass
- □ Artificial Heart Valve
- □ Angina Pectoris
- □ Rheumatic Fever

□ Taking Blood Thinners
□ Cancer
□Radiation □Chemotherapy
Location_____
□ Bisphosphonate Treatment
(Osteoporosis medication)
□ Injections □ Pills
How long?_____
□ Diabetes
Under control? Y N
□ Pills □ Injection □ Diet

□ **Breathing Problems**
- □Asthma
- □ Sinus Problems
- □ COPD
- □ Snoring
- □ Tonsils removed
- □ Sleep Apnea
- □ Allergies/Congestion
- □ CPAP

□ Acid Reflux
□ Ulcers
□ Hemophilia (Bleeding Problems)
□ Epilepsy or Seizures
□ Nervousness
□ Sickle Cell Disease
□ Artificial Joints (including pins)
□ Anemia
□ Glaucoma
□ Arthritis
□ Stroke

□ HIV+/ Aids
□ Venereal Disease
□ Oral Herpes
□ Hepatitis A B or C (circle)
□ Tuberculosis (TB)
□ Liver disease/Jaundice
□ Kidney Trouble
□ Hives or Skin Rash
□ Tobacco Products
- □ Smoke
- □ Dip
- □ Chew
- □ How much per day?_____

□ Drug Addiction
□ Alcoholism
□ Rehabilitation
□ Thyroid Disease
□ Cosmetic Surgery
□ Other_____

Please indicate any jaw related problems:
□ Clicking □ TMJ/TMD □ Clenching □ Grinding □Difficulty opening or closing jaw □ Difficulty chewing □ Pain

Do you currently have any health problems? Y N
If so, what? _____
Are you under medical treatment now? Y N
Primary Care Physician _____ Phone Number_____
Other Doctor(s)_____ Phone Number(s)_____
Previous dental history:
Name of previous dentist_____ Date of last visit_____
Is there any other information you think we need to know to better serve you as our patient?
_____

I certify that these questions have been answered accurately. I understand that providing incorrect information or not including medical information can be dangerous to my health and to healthcare providers. I authorize this office to release any information including diagnosis and records of any treatment or examination rendered during the period of such dental care to third party payors and/or healthcare practitioners. I authorize and request my insurance company to pay the dentist the benefits otherwise payable to me. I understand that my insurance carrier may pay less that the actual bill for rendered services. I agree to be responsible for payment of all services rendered on my or my dependents behalf.
Patient/Guardian Signature_____ Date_____