

Welcome

Thank you for selecting Exquisite Smiles as your dental provider. 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. If you have any questions or need assistance, please ask us – we'll be happy to help.

Patient Information (CONFIDENTIAL)

Today's Date _____
Email Address _____
Cell Phone # _____
Home Phone # _____
Name _____ Birth date _____ Soc. Sec. # _____
Address _____ City/State/Zip _____
Patient or Parent's Employer _____ Work Phone # _____
Business Address _____ City/State/Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Spouse's Name _____ Employer _____ Work # _____
If student, Name of School/College _____ City/State _____ Full-time Part-time
Whom may we Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone # _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ City/State/Zip _____ D.O.B. _____ Home # _____
Employer _____ Work Phone # _____ S.S. # _____
Is this Person Currently a Patient in our office? Yes No

Dental Insurance Information

Primary Dental Insurance

Name of Insured _____ Relationship to Patient _____ Birth date _____
Employer _____ Work Phone # _____ S.S. # _____
Address of Employer _____ City/State/Zip _____
Insurance Company (Dental) _____ Group # _____ ID # _____
Insurance Company Address _____ City/State/Zip _____

Secondary Dental Insurance

Name of Insured _____ Relationship to Patient _____ Birth date _____
Employer _____ Work Phone # _____ S.S. # _____
Address of Employer _____ City/State/Zip _____
Insurance Company (Dental) _____ Group # _____ ID # _____
Insurance Company Address _____ City/State/Zip _____

As a courtesy to our patients, we will gladly submit claims to your insurance company on your behalf. However, it is the patient's ultimate responsibility to be aware of their dental insurance benefits, maximums, limits, and co-payments. Please ask if you have any questions we will be happy to help.

MEDICAL HISTORY

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

CURRENT PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

PHYSICIAN'S ADDRESS _____ PHONE # _____

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has there been any changes in your general health within the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____ |

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any heart ailments |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic joint replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatments |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric care/emotional problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer/colitis/acid reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells/seizures/epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, B or C/ liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes Simplex I or II |
| <input type="checkbox"/> | <input type="checkbox"/> | History of STD and/or Human Papilloma Virus (HPV) |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory problems, emphysema, bronchitis, etc. |

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough or cough that produces blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent swollen glands in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems of the immune system |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for tumor or growth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had abnormal bleeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever required a blood transfusion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any blood disorder such as anemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or use tobacco products now or have you in the past? How much? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use alcohol? How much? _____ |

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates, sedatives, sleeping pills |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Iodine |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine or other narcotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

WOMEN

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking birth control? |

List all prescription and over the counter medications you are taking. _____

Do you wear any removable dental appliances? _____

Do you have any family history of oral cancer? _____

Do you have any specific dental concerns? Please elaborate. _____

What are your goals for your oral health over the next 10+ years? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____
(PARENT OR GUARDIAN IF PATIENT IS A MINOR)