



# NEW ENGLAND SMILES

## Patient Information

Adult/Child: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Gender (Male/Female): \_\_\_\_\_ Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Marital Status (Single/Married/Divorced/Widower): \_\_\_\_\_

Driver's License #: \_\_\_\_\_ S.S.# \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Condo #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone \_\_\_\_\_

When and where are the best times to contact you? \_\_\_\_\_

## Guarantor

*if the patient is a minor, do you have legal custody?* \_\_\_\_\_

Relationship to Patient (Spouse/Parent/Tutor/Legal Guardian/Other): \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Gender (Male/Female): \_\_\_\_\_ Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_

## Emergency Contact

*in case of emergency please provide the following information:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home/Mobile Phone: \_\_\_\_\_

## How did you hear about us?

- Internet     Facebook     Flyer/Mail  
 Newspaper     Yelp     Event  
 Family/Friend     My Insurance Plan  
 TV     Outside Ballon/Sign  
 Other: \_\_\_\_\_

## Payment Options:

- Credit/ Debit Card     Cash/ Check  
 Other



## Dental History

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain? (Yes/No): \_\_\_\_\_

Have you ever had a problem with any previous dental work? (Yes/No): \_\_\_\_\_

Do your gums bleed? (Yes/No): \_\_\_\_\_

How many times a week do you brush? \_\_\_\_\_

How many times a week do you floss? \_\_\_\_\_

## Medical History

Personal Physicians Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Date of

Last Visit: \_\_\_\_\_ Your current health is (Good/Regular/Poor): \_\_\_\_\_

Are you currently under the care of a physician? (Yes/No): \_\_\_\_\_

Please explain: \_\_\_\_\_

Are you taking any prescription/over the counter drugs? (Yes/No): \_\_\_\_\_

Please list each one: \_\_\_\_\_

Do you smoke tobacco in any way? (Yes/No): \_\_\_\_\_

### **Do you have or have you ever had any of the following?**

Please select all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding              | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> AIDS, HIV+                     | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Alcohol or Drug Abuse          | <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Shingles                |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Sickle Cell Disease     |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Herpes, Fever Blisters  | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Tuberculosis Ulcers     |
| <input type="checkbox"/> Cancer, Chemotherapy           | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Colitis                 |
| <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Low Blood Pressure      |
| <input type="checkbox"/> Diabetes Difficulty Breathing  | <input type="checkbox"/> Lupus                   | <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Mitral Valve prolapse   | <input type="checkbox"/> Fainting Spells         |
| <input type="checkbox"/> Frequent Headaches             | <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> Glaucoma                       | Other: _____                                     |  |



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## Are you allergic to any of the following?

Please Select all that apply:

- Aspirin    Penicillin    Jewelry    Latex    Codeine    Azythromycin  
Erythromycin    Tetracycline    Dental Anesthetics    Other: \_\_\_\_\_

### For Women:

Are you taking birth control pills? \_\_\_\_\_

Are you Pregnant? \_\_\_\_\_ If yes, Week # \_\_\_\_\_

Are you nursing? \_\_\_\_\_

## Agreement:

I acknowledge that this information is correct and will be held in the strictest confidence. I authorize Smiley Dental to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any copayment and deductibles that my insurance does not cover. I also undertake to cover all legal and collections cost incurred by Smiley Dental for recovery of payment. I hereby authorize payment directly to Smiley Dental of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company. Please type your full first and last name and date to represent your signature. You may also sign this form once you arrive to the office for your appointment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Office Use Only:**

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments:

\_\_\_\_\_

UPDATE:

Comment: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comment: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_