

## Patient Information

A B C

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Patient's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Patient's Social Security # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Physician \_\_\_\_\_ Oral Surgeon \_\_\_\_\_

Names & Ages of Children in Family \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_ Email \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Dental Insurance Information

Primary Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Do you have dual coverage? Yes  No  If Yes:

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained. I authorize the release of any information as needed for insurance purposes. I hereby authorize payment be made directly from my insurance company to Dr. Chad Smart.

Signature (Parent's signature if minor) \_\_\_\_\_

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing for your dental care. All information will be kept completely confidential.

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- Have you experienced any health problems? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Any major change in your health recently? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Are you currently under physician's care? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Are you currently taking medications? . . . . .  No  Yes List: \_\_\_\_\_  
 Are you allergic to any medications? . . . . .  No  Yes List: \_\_\_\_\_  
 Have you received a blood transfusion? . . . . .  No  Yes Reason: \_\_\_\_\_  
 Have your tonsils or adenoids been removed? . . . . .  No  Yes When: \_\_\_\_\_  
 Have you been in a risk group for AIDS? . . . . .  No  Yes Explain: \_\_\_\_\_

Please check if you have had any of the following conditions:

- |                                  |                             |                              |                          |                             |                              |                                   |                             |                              |
|----------------------------------|-----------------------------|------------------------------|--------------------------|-----------------------------|------------------------------|-----------------------------------|-----------------------------|------------------------------|
| Heart Murmur . . . . .           | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis . . . . .      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Emotional Problems . . . . .      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart Surgery . . . . .          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes . . . . .       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Frequent Headaches . . . . .      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rheumatic Fever . . . . .        | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Disease . . . . . | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nervous/Anxious . . . . .         | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Endocrine Disorders . . . . .    | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Liver Disease . . . . .  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cancer . . . . .                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Prolonged Bleeding . . . . .     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tuberculosis . . . . .   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bone Disorders . . . . .          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Anemia . . . . .                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bronchitis . . . . .     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Growth Disorders . . . . .        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood Disease . . . . .          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma . . . . .         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mouth Breather . . . . .          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Developmental Disorder . . . . . | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Epilepsy . . . . .       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Herpes (Fever Blisters) . . . . . | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hives/Rash . . . . .             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fainting . . . . .       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tonsillitis . . . . .             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Is there any other condition or problem that you think we should know about? \_\_\_\_\_

Comments: \_\_\_\_\_

## DENTAL HISTORY

Dentist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Specialists Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Frequency of dental checkups: Twice a year  Once a year  Only if a problem exists  Never  Date of last visit \_\_\_\_\_

- Is there any unfinished care to be completed with your dentist? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Are you frightened about dental treatment? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Have you had an unpleasant experience in a dental office? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Have you had any face or dental injuries . . . . .  No  Yes Explain: \_\_\_\_\_  
 Do you play any musical instrument? . . . . .  No  Yes What instrument \_\_\_\_\_  
 Have you consulted an orthodontist previously? . . . . .  No  Yes With whom? \_\_\_\_\_  
 Have teeth (either primary or permanent) been removed? . . . . .  No  Yes  
 Have you had any previous orthodontic treatment? . . . . .  No  Yes With whom? \_\_\_\_\_  
 Are you satisfied with prior treatment? . . . . .  No  Yes Explain: \_\_\_\_\_  
 Have you noticed changes in your bite or dental alignment recently? . . . . .  No  Yes Explain: \_\_\_\_\_

What are the chief concerns you have related to the position of your teeth or bite:

- Aesthetic  Cleaning  Comfort  Ability to chew  Stability

Please elaborate: \_\_\_\_\_

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

- Wear or fractures of teeth  Difficulty with cleaning related to alignment of teeth  
 Bone or gum tissue loss  Jaw joint or muscle tightness or discomfort  
 Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)  
 Other: \_\_\_\_\_

Please check if there is a history of:

- Clenching teeth  Muscular soreness around head & neck  Jaw joint soreness  Jaw joint popping  
 Grinding teeth  Headaches (more than normal)  Jaw joint clicking  Ringing in the ears  
 Speech problems (If so, which sounds \_\_\_\_\_)  Mouthbreathing: Awake \_\_\_\_\_ Asleep \_\_\_\_\_

Is there any other information that may be helpful? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by: \_\_\_\_\_