CLARKSTON SMILES

To help us meet all your healthcare needs, please fill out this form completely in ink. We respect your privacy and all your answers are kept confidential. Thanks!

Name _____ Date _____

Soc. Sec.# _____Birth Date _____Home Phone_____

Address _____ City _____ State _____Zip _____

Email address_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parents Employer _____ Work Phone _____

Business Address _____City _____State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

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 _____Home Phone _____

Employer _____ Work Phone _____ SS # _____

Is This Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ Master Card ☐ I wish to discuss the office's payment policy

Insurance Information

Name of Insured_____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, complete the following section

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____ Date Employed _____

Name of Employer _____Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam_____

Are you under a physician's care now? □ Yes □ No (if yes, state reason)_____

Have you ever been hospitalized or had a major operation? □ Yes □ No (if yes, list) _____

Have you ever had a serious head or neck injury? □ Yes □ No (if yes, list) _____

Are you taking any medications, pills or drugs? □ Yes □ No (if yes, list) _____

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No Do you use tobacco? □ Yes □ No

Are you on a special diet? □ Yes □ No Do you use controlled substances? □ Yes □ No

Women: Are you □ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other _____

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

□ AIDS/HIV Positive	□ Chest Pains	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever
□ Alzheimer's Disease	□ Cold Sores/ Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ Anaphylaxis	□ Congenital Heart Disorders	□ 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 Problems	□ Excessive Thirst	□ Herpes	□ Recent Weight Loss	□ Tumors 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

Have you ever had any serious illness not listed above ? □ Yes □ No □ N/A _____

Comments: _____

Patient Dental History

Name of Previous Dentist and Location _____ _____ Date of Last Exam_____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	□	□	7. Do you have frequent headaches?	□	□
2. Are your teeth sensitive to sweets?	□	□	8. Do you clench or grind your teeth?	□	□
3. Are your teeth sensitive to hot or cold?	□	□	9. Have you ever had prolonged bleeding following extractions?	□	□
4. Do you have any sores or lumps in or near your mouth?	□	□	10. Have you had any orthodontic treatment?	□	□
5. Have you had any head, neck or jaw injuries	□	□	11. Do you wear dentures or partials? If yes, date of placement _____	□	□
6. Have you ever experienced any of the following:			12. Have you ever received oral hygiene instructions?	□	□
Clicking	□	□	13. Do you like your smile?	□	□
Pain (joint, ear, side of face)	□	□			
Difficulty in opening or closing	□	□			
Difficulty in chewing	□	□			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to a third party, payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits ortherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for Payment of all services rendered on my behalf or my dependents.

X _____ Signature of Patient (or parent if minor)