



ALL SMILE DENTAL

Patient Information

Date _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Birth date _____

Social Security (SS)# _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Whom may we thank for referring you? _____

Primary Dental Insurance

Subscriber's Name _____

Birth date _____ ID/SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Secondary Dental Insurance

Subscriber's Name _____

Birth date _____ ID/SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Responsible Party Information

Name _____

Birth date _____ SS# _____

Driver's Lic.# _____ State _____

Employer Name _____

Employer Address _____

Employer Phone (____) _____

Spouse's Name _____

Birth date _____ SS# _____

Driver's Lic.# _____ State _____

Spouse's Employer _____

Spouse's Employer Phone (____) _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage as provided above and assign directly to All Smile Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. All Smile Dental may use my information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my account balance is paid in full.

Signature of Responsible Party

Please print name of Responsible Party

Date

Relationship to Patient

Contact Information

Home (____) _____ Work Phone (____) _____ Ext _____ Cell Phone (____) _____

Spouse's Work (____) _____ Email _____ Cell Phone (____) _____

IN CASE OF EMERGENCY, CONTACT (someone who does not live in your household.) Relationship _____

Name _____ Address _____

Home (____) _____ Work Phone (____) _____ Ext _____ Cell Phone (____) _____





Dental History

Reason for today's visit _____ Chew on one side of mouth Yes No Mouth breathing Yes No
 _____ Cigarette, pipe, or _____ Mouth pain, brushing Yes No
 Former Dentist _____ cigarsmoking Yes No Orthodontic treatment Yes No
 City/State _____ Clicking or popping jaw Yes No Pain around ear Yes No
 Date of last dental visit _____ Dry mouth Yes No Periodontal treatment Yes No
 Date of last dental X-rays _____ Fingernail biting Yes No Sensitivity to cold Yes No
 Place a mark on "yes" or "no" to indicate Food collection between Yes No Sensitivity to heat Yes No
 if you have had any of the following: Foreign objects Yes No Sensitivity to sweets Yes No
 Grinding teeth Yes No Sensitivity when biting Yes No
 Bad breath Yes No Gums swollen or tender Yes No Sores or growths in Yes No
 Bleeding gums Yes No Jaw pain or tiredness Yes No your mouth
 Blisters on lips or mouth Yes No Lip or cheek biting Yes No How often do you floss? _____
 Burning serration on tongue Yes No Loose teeth or broken fillings Yes No How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No
 Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
extractions or surgery	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	or neck
Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No

Women:
 Are you pregnant? Yes No Due date _____
 Taking birth control pills? Yes No Are you nursing? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:

 Pharmacy Name _____
 Phone (_____) _____

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

