SOUTH MOUNTAIN DENTAL

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Welcome! *Thank you for choosing our office for your dental needs. To help us meet all of your needs, please fill out this form as completely as possible. If you need help or have any questions, please ask. Thank you.*

Today's Date _____

Patient Information (Confidential)

Last Name _____ First Name _____ MI _____ Age _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Birthday _____ Social Security Number _____

Email _____

Do You Prefer To Receive Calls At ☐ Home ☐ Cell ☐ Work

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status ☐ Student ☐ Employed ☐ Not Employed ☐ Retired

Employer _____ City, State _____

Emergency Contact _____ Phone _____ Relationship _____

Insurance/Responsible Party Information

Insured/Responsible Party _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Birthday _____ Social Security Number _____

Employer _____ City, State _____

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Member/Subscriber ID Number _____ Group Number _____

Referral Information

How did you hear about our office? ☐ Current Patient (who?) ☐ Post Card ☐ Internet ☐ Drive-by ☐ Other

If other, how? _____

Patient Health History

Physician _____ *Office Phone* _____ *Last Exam* _____

	YES	NO
1. Are you under medical treatment now?.....	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	☐	☐
3. Are you taking any medications, including non-prescription medicines?.....	☐	☐
If yes, what are you taking? _____		
_____		
_____		
_____		
_____		
4. Do you use tobacco?.....	☐	☐

5. Are you allergic to or have you had any reaction to any of the following?	**YES**	**NO**
Codeine.....	☐	☐
Dental Anesthetics.....	☐	☐
Erythromycin.....	☐	☐
Latex.....	☐	☐
Metals.....	☐	☐
Penicillin.....	☐	☐
Tetracycline.....	☐	☐
Other _____	☐	☐

6. WOMEN ONLY:	YES	NO
a) Are you pregnant or could you be pregnant?.....	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking birth control?	☐	☐

7. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding	☐	☐	Heart Disease	☐	☐	Respiratory Disease	☐	☐
Allergies (seasonal)	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Alzheimer's	☐	☐	Hepatitis (Type? _____)	☐	☐	Sexually Transmitted Disease	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐	Sinus Problems	☐	☐
Angina	☐	☐	HIV/AIDS	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Joint Replacement	☐	☐	Thyroid Problems	☐	☐
Autism Spectrum Disorder	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Ulcers/Stomach Problems	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Other _____	☐	☐
Epilepsy	☐	☐	Pacemaker	☐	☐	Other _____	☐	☐
Fainting	☐	☐	Radiation Therapy	☐	☐	Other _____	☐	☐

Patient Dental History

Reason for today's visit: _____

Date of Last Exam: _____ *Date of Last X-rays:* _____ *Former Dentist:* _____

How often do you brush? _____ *How often do you floss?* _____

Please check any of the following that apply to you:

☐ Bleeding gums	☐ Grinding teeth	☐ Prolonged bleeding following extractions
☐ Bad breath	☐ Clicking or popping jaw	☐ Pain on chewing or biting
☐ Periodontal treatment	☐ Food collecting between teeth	☐ Sores or growths in your mouth
☐ Orthodontic treatment	☐ Frequent headaches	Sensitivity to: ☐ Hot ☐ Cold ☐ Sweets

Authorization and Release

I certify that I have read and understand the above information, to the best of my knowledge. I have answered the above questions as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I authorize South Mountain Dental to release any information, including the diagnosis, and/or records of any treatment or examination rendered to my dependent or me during the period of such dental care, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, any insurance benefits otherwise 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 behalf of my dependents or myself.

Patient Signature _____ *Date* _____

(or Parent/Guardian, if minor)