SOUTH MOUNTAIN DENTAL

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Welcome! *Thank you for choosing our office for your dental needs. To help us meet all 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* _____ *Gender* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Cell Phone _____ *Work Phone* _____ *Home Phone* _____

Birthday _____ *Social Security Number* _____

Email _____

Emergency Contact _____ *Phone* _____ *Relationship* _____

Marital Status ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Widowed*

Employment Status ☐ *Student* ☐ *Employed* ☐ *Not Employed* ☐ *Retired*

Employer _____ *City, State* _____

Dental Insurance Information

Insurance Subscriber _____ *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 Search* ☐ *Drive-by* ☐ *Other*

If other, how? _____

Patient Health History

Physician _____ Office Phone _____ Last Exam _____

Pharmacy _____ Street and City _____ Phone _____

	YES	NO
1. Are you under medical treatment now?.....	☐	☐
2. Are you taking any medications, including non-prescription medicines?.....	☐	☐

If yes, what are you taking?

_____

_____

_____

_____

_____

_____

	YES	NO
4. Do you smoke, use tobacco, or vape?.....	☐	☐

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
Are you pregnant or could you be pregnant?.....	☐	☐

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

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding……..…..	☐	☐	Heart Disease…….……	☐	☐	Radiation Therapy……...	☐	☐
Allergies (seasonal).....…..	☐	☐	Heart Murmur……...	☐	☐	Respiratory Disease……...	☐	☐
Alzheimer's…….....	☐	☐	Hepatitis .....…	☐	☐	Rheumatic Fever…….…….....	☐	☐
Anemia…….....	☐	☐	High Blood Pressure….……	☐	☐	Sexually Transmitted Disease….	☐	☐
Angina……	☐	☐	High Cholesterol……..……	☐	☐	Sinus Problems……...	☐	☐
Asthma…….....	☐	☐	HIV/AIDS…….……	☐	☐	Sleep Apnea……..……	☐	☐
Autism Spectrum Disorder..	☐	☐	Joint Replacement……..……	☐	☐	Stroke……...……	☐	☐
Diabetes……..	☐	☐	Kidney Disease……..……...	☐	☐	Thyroid Problems……..……..	☐	☐
Emphysema……..……	☐	☐	Liver Disease……..……..…	☐	☐	Tuberculosis……	☐	☐
Epilepsy……..	☐	☐	Low Blood Pressure….….....	☐	☐	Ulcers/Stomach Problems……	☐	☐
Fainting……...	☐	☐	Pacemaker……...	☐	☐	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
- ☐ Bad breath
- ☐ Periodontal treatment
- ☐ Snoring
- ☐ Grinding teeth
- ☐ Clicking or popping jaw
- ☐ Food collecting between teeth
- ☐ Frequent headaches
- ☐ Prolonged bleeding following extractions
- ☐ Pain on chewing or biting
- ☐ Sores or growths in your mouth

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 that I am ultimately responsible for payment of all services rendered on behalf of my dependents or myself, including any services for which my insurance does not pay or pays less than expected.**

Patient Signature _____ Date _____

(or Parent/Guardian, if minor)