Thank you for selecting our dental practice! We will strive to provide you with the best possible dental care. To Help us meet allyour dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us we will be happy to help.

(PLEASE PRINT)

Patient Name:_____
(Last) (First) (Middle)

SSN:_____ Date of Birth:_____

Sex: Male or Female **Marital Status:** Married Divorce Widowed Partnered Single

Home Address:_____

City, State & Zip:_____

Home Phone:_____ Cell:_____

Work Phone:_____ Email:_____

Employer Name:_____ Occupation:_____

Work Address:_____

Who may we thank for referring you?_____

***Please list an Emergency Contact not living with you:**

Name:_____ Phone #:_____

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone#		Insurance Phone#	

Patient confidentiality is top priority at Amazing Smiles. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy

Please list any family members who we may discuss your dental treatment:

Name:_____

Relationship:_____ Phone:_____

(Turn Over)

MEDICAL HISTORY INFORMATION

Name of Physician:_____ Phone:_____

Do you have or have ever had any of the following? Please check those that apply:

_Allergies/Hay Fever	_Diabetes	_Heart Surgery*	_Yellow Jaundice
_Anemia	_Epilepsy/Seizures	_Hepatitis	_Rheumatic Fever
_Angina	_Excessive Thrist	_High Blood Pressure	_Rheumatic Fever
_Arthritis	_Fainting or Dizziness	_HIV/AIDS*	_Sickle Cell Disease
_Artifical Joints*	_Fever Blister/Cold Sores	_Kidney Problems	_Sinus Problems
_Artifical Heart Valves*	_Frequwnt Cough	_Liver Problems	_Stroke
_Asthma	_Glaucoma	_Mental Disorders	_Surgical Shunt*
_Breathing Problems	_Heart Disorder	_Mitral Valve Proapse	_Thyroid Problems
_Cancer	_Heart Infection	_Osteoporosis	_Tuberculosis
_Chemical Dependency	_Heart Murmur	_Radiation Treatment	_Ulcers
_Chemotherapy	_Heart Pace Maker*	_Respiratory Problems	_Veneral Disease

***THIS CONDITION MAY REQUIR ANTIBIOTIC PREMEDICATION FOR CERTAIN DENTAL PROCEDURES.**

Are you under medical treatment now?_____
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?_____ If yes, please explain_____
Are you taking any medications or herbals?_____
Are you allegric to any medications or substances?_____
Have you or do you use any controlled substance?
Do you smoke? Yes or NO If yes how many packs a day?_____
Are you taking any medication(s) including non-prescription medicine? Yes or No If yes, what medication(s) are you taking?_____
_____

WOMEN (Please check): _Pregnant _Breastfeeding _Taking oral contraceptives

I cerify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benfits otherwise payable of all services rendered on my behalf or my dependents. I understand that my dental insurance carrier pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature:_____ Date:_____