The Smile and Implant Center
201-991-1055

Patient Health Record

In order to help us render the proper dental services to you, would you please be kind enough to fill out and sign both sides of this form. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Date_____

Name_____ Nickname _____

Home Address _____

_____

Home Phone_____ Cell _____

Name of Employer _____

Business Address _____

_____

Business Phone_____ Fax_____

Are you connected to the internet?

Home: ☐ Y ☐ N

Work: ☐ Y ☐ N

Can we e-mail you? ☐ Y ☐ N

What is your e-mail address?

Home: _____

Work: _____

If we must call you, is it permissible to call you at your place of business? ☐ Yes ☐ No

Occupation_____ Driver's License # _____

Date of Birth_____ /_____ /_____ ☐ M ☐ F Your Social Security # _____

Marital Status_____ Spouse's Name_____

Spouse's Social Security #_____ Spouse's Date of Birth _____ /_____ /_____

Name of your primary dental insurance_____ Group # _____

Name of your secondary dental insurance_____ Group # _____

Person to contact in case of emergency_____ Phone # _____

Referred By_____

Billing and Payment Procedure

Our computer is designed to establish only a family account designating a person responsible for that account. Please refer to our payment options which will make our high quality dental care more affordable. Any billing on accounts more than 90 days past due regardless of any outstanding insurance payments, will incur 18% annual interest or 1½% per month.

Dental Insurance

I hereby authorize and give consent to sign my name and/or electronically submit my insurance to my and/or my spouses dental insurance company for payment of work completed.

I understand and agree that I am fully responsible for my entire account. Should my account become delinquent, any accumulated interest, late fees, collection fees, and any reasonable attorney's fees will be added to my account.

Person responsible for payment: ☐ Self ☐ Husband ☐ Wife ☐ Father ☐ Mother ☐ Other _____

Name_____

Address ☐ Same as above

_____

_____

PLEASE NOTE:

Any necessary billing will be done by our friendly staff and billed only to the insured's responsible party. If you have any questions please feel free to ask us.

Thank You

X_____

Patient's Signature

PLEASE COMPLETE BOTH SIDES - THANK YOU

HEALTH RECORD

Medical Alert

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

	Yes	No
Heart trouble	☐	☐
Cardiac pacemaker	☐	☐
Heart murmur	☐	☐
Rheumatic heart fever	☐	☐
High blood pressure	☐	☐
Anemia	☐	☐
Leukemia	☐	☐
Radiation therapy for cancer	☐	☐
Sinus problems	☐	☐
Hepatitis (Yellow Jaundice)	☐	☐
Diabetes or high blood sugar	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐
Psychiatric treatment	☐	☐
Hypoglycemia or low blood sugar	☐	☐
Asthma	☐	☐
Arthritis	☐	☐
Fainting problems	☐	☐
Kidney disease	☐	☐
Thyroid disease	☐	☐
AIDS related virus	☐	☐
Allergy to aspirin	☐	☐
Allergy to codeine	☐	☐
Allergy to penicillin	☐	☐
Allergy to novocaine	☐	☐
Allergy to Anesthetic	☐	☐
Other Drug Allergy	☐	☐
List:_____		
_____		
Gagging problems	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐

	Yes	No
Have you been a patient in a hospital in the past 2 years?	☐	☐
Have you been under the care of a Physician?	☐	☐
Have you ever been seriously ill?	☐	☐
Are you now taking or have you taken any medicine or drugs in the past year?	☐	☐
Do you smoke?	☐	☐
If so, how many packs per day? _____		
Do you take vitamin supplements?	☐	☐
Are you currently taking birth control pills?	☐	☐
Are you now pregnant?	☐	☐
Are you currently breastfeeding a baby?	☐	☐

Is there anything else we should know about?

_____

_____

_____

Physician's Name:_____

Address:_____

_____

Phone Number: _____

Dentist Name: _____

Address:_____

_____

Phone Number: _____

List all medications being taken:_____

_____

_____

Have you ever been diagnosed with osteoporosis, if so, name of medication(s) being taken: _____

_____

Are you taking any blood thinners, if so, name of medication(s) being taken:

_____

Reason for Visit:

_____

_____

_____

Do you like your smile right now? Yes ☐ No ☐

Are you interested in whitening your teeth? Yes ☐ No ☐

If you could wave a magic wand and change your smile, what would you change?

_____

_____

1. Do you fear Dental Care? ☐ Very Much ☐ Somewhat ☐ No
2. Have you had regular check-ups in the past? ☐ Yes ☐ No
3. How long since your last visit to a dentist? _____
4. Was it for, ☐ Routine Care ☐ Emergency Care
5. Is this visit for, ☐ Routine Care ☐ Emergency Care
6. Other comments: _____

_____

I hereby authorize and consent the giving of an anesthetic, the performing of a dental related operation or any other procedure necessary for the diagnosis and treatment of the above patient while a patient at the office of The Smile and Implant Center.

Patient Signature: X_____ Date:_____