



Patient Information

Name _____

Last First Middle Initial Nickname

Address _____

Street

City State Zip

Employer _____ Driver's License Number _____

Birth Date _____ Height _____ Weight _____

Phone Home _____ Social Security Number _____

Work _____ Male ___ Female ___

Mobile _____

Email Address _____

Emergency Contract _____ Phone Number _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security Number _____

Employer _____ Insurance Co. _____

Insurance Co. Phone Number _____ Group Number _____

Subscriber Date of Birth _____ Relation to Patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security Number _____

Employer _____ Insurance Co. _____

Insurance Co. Phone Number _____ Group Number _____

Subscriber Date of Birth _____ Relation to Patient _____

I hereby authorize payment directly to **Lifetime Smiles** of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize **Lifetime Smiles** to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient Under 18

Responsible Party _____ Relation to Patient _____

Address _____

Telephone Number _____

Medical History & Information (please check all that apply)

Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ AIDS
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sexual Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline
- Other _____

Do You Smoke or use Tobacco

Yes _____ No _____

If Female

Are you taking birth control pills

Yes _____ No _____

Are you pregnant

Yes _____ No _____

Are you nursing

Yes _____ No _____

Please List Any Medications You Are Currently Taking _____

Physician's Name and Phone Number _____

Dental History

What is the main reason for your visit today? _____

Date of Last Dental Examination _____ Dentist's Name (optional) _____

Date of Last Dental X-Rays _____ Date of last physical examination? _____

	Yes	No
Are you having pain or discomfort at this time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel very nervous about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you need to pre-medicate with antibiotics prior to dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a bad experience in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a patient in the hospital during the past two years	<input type="checkbox"/>	<input type="checkbox"/>
Have you been under the care of a medical doctor during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any vitamins or herbal supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any excessive bleeding requiring special treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken prescription Fen Phen?	<input type="checkbox"/>	<input type="checkbox"/>
Are there now any growths or sores in or around your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any trouble chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in or near your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you habitually clench or grind your teeth during the day or night?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced clicking or popping of your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or your spouse snore?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have gum problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now have bleeding gums or any other gum condition?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have gum disease (periodontal disease)?	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything related to your medical or dental history that you have not indicated above? If yes, please explain _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENT/GUARDIAN SIGNATURE

DATE

Reviewed By:

DOCTOR'S SIGNATURE

DATE