Authentic Smiles

REGISTRATION

Patient's Name:_____ Date:_____
First MI Last

Single ☐ Seperated ☐
Married ☐ Divorced ☐
Widowed ☐

Gender:_____ Birthdate:_____ Age:_____

Home Phone:_____ Work: _____ Cell:_____

Email:_____ Soc. Sec. #:_____

Home Address (not a PO BOX):_____
Apartment #

_____
City State Zip Code

Patient's Employer:_____ Present Position:_____ How Long:_____

Business Address:_____
Street City State Zip

Spouse's Name:_____ Birthdate:_____ Soc. Sec. #_____
First MI Last

Spouse's Employer:_____ Present Position:_____ How Long:_____

Business Address:_____
Street City State Zip

Person Financially Responsible:_____ Relationship:_____

Billing Address (if not Home Address):_____
Street City State Zip

DENTAL INSURANCE INFORMATION

Primary Carrier		Secondary Carrier	
Employer		Employer	
Insurance Co.		Insurance Co.	
Insurance Co. Address		Insurance Co. Address	
Policy #	Group #	Policy #	Group #
Union Name	Local #	Union Name	Local #

Purpose of this visit:_____

PLEASE COMPLETE THE OTHER SIDE

MEDICAL HISTORY

CIRCLE any of the following which you have had:

Heart conditions or trouble
Chest pains
Shortness of breath
Ankles swell
Heart murmur
Rheumatic fever
Scarlet Fever
High or low blood pressure
Fainting or dizziness
Convulsios or seizures
Epilepsy
Stroke
Severe of frequent headaches
Psychiatric treatment
Alcohol or drug problem
AIDS / ARC / HIV positive

Blood transfusions
Prolonged or excessive bleeding
Anemia or blood disorder
Hepatitis or jaundice
Ulcers
Venereal Disease
Herpes / fever blisters
Cold sores
Kidney trouble
Diabetes
Thyroid condition
Arthritis / Rheumatism / Gout
Pain in jaw joints
Tuberculosis (TB) or Emphysema
Asthma
Cancer / Tumor / Growth

Have you had any allergies or bad reactions to any medications? Yes ☐ No ☐
Which ones?_____

Are you taking any medications, pills or drugs? Yes ☐ No ☐
Please list_____

Are you under a physician's care now? Yes ☐ No ☐
For what?_____

Have you ever been hospitalized or had a serious illness? Yes ☐ No ☐
Explain_____

Do you have any disease, condition or problem not listed? Yes ☐ No ☐

_____

Person to contact in case of emergency:_____

_____

Physician's Name:_____ Date of last Physical exam:_____

The preceding is correct to the best of my knowledge. If I ever have a change in my health or medication, I will inform the dentist at my next appointment. I hereby authorize the dentist and staff to administer such medications and to perform such treatment as may be indicated for proper dental care. I authorize the release of any information concerning my health advice or treatment to or from another dentist and to my insurance companies. I hereby assign any insurance benefits to Authentic Smiles, and I understand that insurance may pay less than the total cost. I understand that I am personally responsible for all cost of dental treatments. I give permissions to Authentic Smiles and its employees to display my photographs and/or radiographs for teaching and illustrative purposes.

Signature:_____ Date:_____

Medical Updates:_____