WELCOME

Drs. Smith & Robinson, PA • 509 East Main Street • Lexington, SC 29072 • (803) 359-9991

1 ABOUT YOU

NAME _____ I prefer to be called _____

❑ Male ❑ Female Birthdate ____/____/____ Social Security # _____

HOME ADDRESS _____

_____ EMAIL ADDRESS: _____

❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED DRIVER'S LICENSE # _____

HOME PHONE # _____ CELL# _____ WORK PHONE # _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

HOW LONG THERE? _____ OCCUPATION _____

2 PARENT / SPOUSE INFORMATION

NAME _____

EMPLOYER _____

WORK # _____ BIRTHDATE ____/____/____

3 DENTAL INSURANCE

INSURANCE COMPANY _____

ADDRESS _____

TELEPHONE _____ POLICY # _____

INSURED'S NAME _____ RELATION _____

INSURED'S BIRTHDATE _____ INSURED'S SS # _____

INSURED'S EMPLOYER _____

I HAVE RECEIVED THE FOLLOWING TREATMENT PLAN. I AUTHOIRIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____

SIGNED (PATIENT OR PARENT IF MINOR) DATE SIGNED (INSURED PERSON) DATE

SECONDARY DENTAL INSURANCE

INSURANCE COMPANY _____

ADDRESS _____

TELEPHONE _____ POLICY # _____

INSURED'S NAME _____ RELATION _____

INSURED'S BIRTHDATE _____ INSURED'S SS # _____

INSURED'S EMPLOYER _____

4 MEDICAL HISTORY

PERSONAL PHYSICIAN _____

PHONE # _____ LAST VISIT _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____

(CONTINUED ON BACK)

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MEDICAL HISTORY cont.

Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain:

Are you taking any prescription/ over-the-counter drugs?
❑ Yes ❑ No
Please list each one:

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack/Stroke
Y N Cancer/ Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+/AIDS
Y N Heart Surgery/Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High/Low Blood Pressure
Y N Fever Blisters
Y N Severe/Frequent Headaches
Y N Psychiatric Problems
Y N Epilepsy/Seizures/Fainting Spells
Y N Diabetes/Tuberculosis (TB)
Y N Drug/Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia/Abnormal Bleeding
Y N Ulcers/Colitis
Y N Congenital Heart Defect
Y N Anemia/Radiation Treatment
Y N Asthma/Arthritis
Y N Difficulty Breathing
Y N Hospitalized for any reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema/Glaucoma

Please list any medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Latex
Y N Other

Please list any other drugs that you are allergic to:

FOR WOMEN: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No
Are your nursing? ❑ Yes ❑ No

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DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? ❑ Yes ❑ No
Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor
Do you like your smile? ❑ Yes ❑ No
Do your gums ever bleed? ❑ Yes ❑ No
How many times a week do you floss?
How many times a day do you brush?
Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

SIGNATURE DATE

THANK YOU

Thank you for filing out this form completely. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

SIGNATURE DATE

***** OFFICE USE ONLY *** OFFICE USE ONLY *** OFFICE USE ONLY *** OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials Date

DOCTOR'S COMMENTS