

WELCOME

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

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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 _____

PARENT / SPOUSE INFORMATION

2

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 UNDER-
STAND 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 _____

MEDICAL HISTORY

4

PERSONAL PHYSICIAN _____

PHONE # _____ LAST VISIT _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____

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

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

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

