



### General Information

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_ Male Female  
Social Security#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
How would you prefer to be contacted? \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Whom may we contact in the case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

### Dental Insurance

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Are you the policy holder? Yes No If no, what is your relation to the policy holder? \_\_\_\_\_  
Policy holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_  
Plan ID#: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_  
Do you have secondary insurance? YES NO  
If yes, please let our administrative team know so that we may gather the necessary information.

I authorize Authentic Smiles to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize that payment be made directly to Authentic Smiles for services rendered. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all the information on this sheet and have verified the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

\_\_\_\_\_  
Signature/Parent if minor

\_\_\_\_\_  
Date

## Medical Information

Your current health:    GOOD    FAIR    POOR

Current Physician: \_\_\_\_\_

Please list any medications that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Women:

Are you pregnant?    YES    NO    Due date: \_\_\_\_\_

Are you nursing?    YES    NO

### Do you have or having ever been treated for any of the following diseases or conditions?

*(select all those that apply)*

Abnormal Bleeding	Hepatitis
Alcohol/Drug Abuse	Herpes/Fever Blisters
Anemia	High Blood Pressure
Arthritis	HIV/AIDS
Artificial joints/bones/valves	Kidney Problems
Asthma	Liver Disease
Blood Transfusion	Low Blood Pressure
Cancer	Mitral Valve Prolapse
Congenital Heart Defect	Pacemaker
Diabetes	Psychiatric problems
Difficulty Breathing	Radiation treatment
Emphysema	Rheumatic Fever
Epilepsy	Scarlet Fever
Fainting spells	Seizures
Frequent Headaches	Shingles
Glaucoma	Sinus Trouble
Gum Disease	Stroke
Hay Fever	Thyroid Problems
Heart Attack	Tuberculosis (TB)
Heart Murmur	Ulcers
Heart Surgery	Venereal Disease (STD)
Hemophilia	

Do you smoke or chew tobacco?    YES    NO

Do you need to be pre-medicated for Mitral Valve Prolapse, Heart Murmur, or any kind of joint/bone/valve replacement?

YES    NO

Please select and of the following which you are allergic to:

Aspirin	Codeine	Dental Anesthetics
Latex	Penicillin	Erythromycin
Metals	Sulfa	Iodine

Please list any other allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Dental Information

Previous Dentist: \_\_\_\_\_

City/State: \_\_\_\_\_

Last Dental Visit: \_\_\_\_\_

Current Dental health:    GOOD    FAIR    POOR

Are you happy with your smile?    YES    NO

If no, please tell us why:

\_\_\_\_\_  
\_\_\_\_\_

Would you like for your teeth to be whiter?

Would you like for your teeth to be straighter?

Have you had orthodontic treatment?

Do you clench or grind your teeth?

Do you have pain in your jaw or face?

Do you have a bad odor/taste in your mouth?

Do your gums bleed when brushing/flossing?

Are your teeth sensitive to pressure?

Are your teeth sensitive to hot?

Are your teeth sensitive to cold?

Are your teeth sensitive to sweets?

Does food catch between your teeth?

Do you have silver or discolored fillings or un-natural looking crowns or bridges that you wished looked different?    YES    NO

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us about any other dental concerns that you may have or any information that you feel is important for us know:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us what you are looking for in a dental office, what is most important to you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_