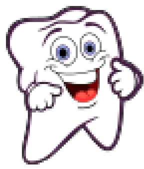

# SMILEY DENTAL

## Patient Welcome Form

**Patient Information** *Adult/Child:* _______________ Date:______________

Last Name: _________________________ First Name: _________________________
MI:_______
Gender (Male/Female): __________ Email: __________________________ Birthdate:__________
Marital Status (Single/Married/Divorced/Widower): ________________________________________
Driver's License #: __________________________ S.S.# _________________________________
Address: __________________________________________ Apt./Condo #: _________________
City: __________________________ State: _______________ Zip Code: ____________________
Home Phone: ___________________________ Mobile Phone: _____________________________
Occupation: ____________________________ Work Phone:

When and where are the best times to contact you? _______________________________________

**Guarantor** *if the patient is a minor, do you have legal custody?* ___________

Relationship to Patient (Spouse/Parent/Tutor/Legal Guardian/Other): _________________________
Last Name: _________________________ First Name:________________________ MI:________
Gender (Male/Female):__________ Email: ________________________ Birthdate:___________

**Emergency Contact** *in case of emergency please provide the following information:*

Name: _______________________________________ Relationship: _________________________
Work Phone: ________________________ Home/Mobile Phone: _____________________________

**How did you hear about us?:**

- ○Yellow Pages
- ○Family/Friend
- ○Event
- ○Radio
- ○TV
- ○Internet
- ○Flyer/Mail
- ○Outside Sign/Balloon
- ○Newspaper
- ○My Insurance Plan
- ○Yelp
- ○Facebook
- ○Other

**Payment Options:**

- ○Insurance
- ○Credit/ Debit Card
- ○Cash/ Check

## Dental History

Why have you come to the dentist today?:

_____________________________________________

Are you currently in pain? (Yes/No): ___________________________________

Have you ever had a problem with any previous dental work? (Yes/No): ______________________

Do your gums bleed? (Yes/No): ______________________________

How many times a week do you brush? ______________________________

How many times a week do you floss? _______________________________

## Medical History

Personal Physicians Name: _______________________ Phone Number:___________________

Date of Last Visit: ___________ Your current health is (Good/Regular/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: ____________________________________________________________

Do you smoke tobacco in any way? (Yes/No): _______________________________

## Do you have or have you ever had any of the following?

Please select all that apply:

○Abnormal Bleeding
○AIDS, HIV+
○Alcohol or Drug Abuse
○Anemia
○Arthritis
○Artificial Bones/Joints/Valves
○Asthma
○Blood Transfusion
○Cancer, Chemotherapy
○Colitis
○Congenital Heart Defect
○Diabetes Difficulty Breathing
○Epilepsy
○Fainting Spells
○Frequent Headaches
○Glaucoma

○Hay Fever
○Heart Attack
○Heart Surgery
○Heart Murmur
○Hemophilia
○Hepatitis
○Herpes, Fever Blisters
○High Blood Pressure
○Kidney Problems
○Liver Disease
○Low Blood Pressure
○Lupus
○Mitral Valve prolapse
○Pacemaker
○Psychiatric Problems
○Radiation Treatment

○Rheumatic; Scarlet Fever
○Seizures
○Shingles
○Sickle Cell Disease
○Sinus Problems
○Stroke
○Thyroid Problems
○Tuberculosis Ulcers

Other: ________________

## Are you allergic to any of the following? :

Please select all that apply:

○Aspirin ○Penicillin ○Jewelry ○Latex

○Codeine ○Erythromycin ○Tetracycline ○Dental Anesthetics

Other: ______________________

**For Women**:

Are you taking birth control pills? __________

Are you pregnant? ___________

Week #: __________

Are you nursing? ___________

## Agreement:

I acknowledge that this information is correct and will be held in the strictest confidence. I authorize Smiley Dental to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment directly to Smiley Dental of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company. Please type your full first and last name and date to represent your signature. You may also sign this form once you arrive to the office for your appointment.

Signature:___________________________________________ Date: ______________________

***Office Use Only:***

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

Initials: ___________________________ Date:______________________

Doctor's comments: ______________________________________________________________

UPDATE:

Comment: ________________________________________________________________________________

Signature:_______________________________________________ Date: ________________________

Comment: ________________________________________________________________________________

Signature:_______________________________________________ Date: ________________________