NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle): _____ TITLE: _____

HOME ADDRESS: _____

PREFERRED NAME: _____ SS NO: ___-___-___ DOB: ___/___/___

HOME PHONE: _____ MARITAL: S/M/D/W

WORK PHONE: _____ SEX: M / F

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____ PHONE: _____

SS NO: ___-___-___ EMPLOYER: _____

DOB : ___/___/___ ADDRESS : _____

INSURANCE CO: _____

ADDRESS: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____ PHONE: _____

SS NO: ___-___-___ EMPLOYER: _____

DOB : ___/___/___ ADDRESS : _____

INSURANCE CO: _____

ADDRESS: _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR ACCT: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO: _____-_____-_____ DOB: _____/_____/_____

HOME PHONE: _____ WORK PHONE: _____

VERIFIED BY: _____

I certify that I have read and understand the above information to the best of my knowledge. The above information is accuratel provided. I authorize Jyoti R. Shah, DDS, Inc., dba: The Smile Center to release any information about me or my dependents duri the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company pay directly to the Smile Center group insurance benefits otherwise payable to me. I understand that my dental insurance carrie may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependents. I further agree that if this account is turned over to a collection agency, I will be responsible for all collectio agency fees, court costs and reasonable attorney fees.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

For Office Use Only
ID:

Patient's Name: | Today's Date: | Date of Last Visit: | Date of Medical History:

Address: | City State Zip:

Home Phone: | Birth Date: | Social Security Number: | Marital Status:

Guarantor 1: | Work Phone:

Guarantor 2: | Work Phone:

Physician Name: | Physician Phone:

Pharmacy: | Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex: | If female please answer the following:

Y N
☐☐ Are you taking Birth Control Pills?
☐☐ Are you pregnant? If Yes, # of weeks
☐☐ Are you nursing?

Please answer the following:

Y N
☐☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP: Heart Rate:

Weight:

Y N	Conditions
☐☐	Abnormal Bleeding
☐☐	Alcohol Abuse
☐☐	Allergies
☐☐	Anemia
☐☐	Angina Pectoris
☐☐	Arthritis
☐☐	Asthma
☐☐	Bleeding Gums
☐☐	Cancer
☐☐	Chest Pains
☐☐	Colitis
☐☐	Convulsions
☐☐	Diabetes
☐☐	Difficulty Breathing
☐☐	Drug Abuse
☐☐	Emphysema
☐☐	Epilepsy
☐☐	Fainting Spells
☐☐	Glaucoma
☐☐	HIV+ AIDS
☐☐	Hay Fever
☐☐	Heart Disease

Y N	Conditions
☐☐	Heart Murmur
☐☐	Heart Surgery
☐☐	Hemophilia
☐☐	High Blood Pressure
☐☐	Joint Replacement Or Implant
☐☐	Kidney Disease
☐☐	Liver Disease
☐☐	Low Blood Pressure
☐☐	Mitral Valve Prolapse
☐☐	Other:
☐☐	Pace Maker
☐☐	Psychiatric Problems
☐☐	Recent Weight Loss
☐☐	Respiratory Problems
☐☐	Rheumatic Fever
☐☐	Seizures
☐☐	Sexually Transmitted Disease
☐☐	Sickle Cell Disease
☐☐	Sinus Problems
☐☐	Stomach Troubles
☐☐	Stroke
☐☐	Swollen Ankles

Y N	Conditions
☐☐	Taken Fen-Phen
☐☐	Thyroid Problems
☐☐	Tuberculosis
☐☐	Ulcers
☐☐	Sensitive Teeth
☐☐	Hepatitis

Y N	Allergies
☐☐	Aspirin
☐☐	Codeine
☐☐	Dental Anesthetics
☐☐	Erythromycin
☐☐	Jewelry
☐☐	Latex
☐☐	Metals
☐☐	Penicillin
☐☐	Tetracycline

Other: _____

Medications:

Notes:

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)