Got Smile
dental group

Mark G. Smith, D.D.S.

Name: _____ **Birthdate:** ____/____/____
(Last) (First) (Middle) M D Y

(Please check one) Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Wishes to be called (nickname)_____ **S.S.N.:** _____

Sex: Male ___ Female ___ Single ___ Married ___ Divorced____ Occupation_____

Home Address:_____
(Street) (Apt #) (City) (State) (Zip)

Telephone:_____ _____ _____
(Home) (Cell) (Work)

Email:_____ **Do we have permission to text and email you?** _____

Emergency Contact _____ **Telephone**_____

Preferred Appointment Times: Day of the week_____**Time of day**_____

Whom may we thank for referring you? _____

PLEASE NOTE WE MUST HAVE A HIPAA SIGNATURE BELOW!

NOTICE OF PRIVACY PRACTICES

Please review this document which is available on our website with our Patient Forms under the "For New Patients" tab.

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY. (A COPY OF THIS HIPPA POLICY WILL BE MADE AVAILABLE UPON REQUEST.) Please provide our office with your photo identification (driver's license) for HIPPA compliance.

By signing below I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Signed_____ Date_____

Printed Name_____

****Please review and sign the Got Smile Dental Group Financial Policy and HIPAA Consent forms in addition to this form, also found with our Patient Forms under the "For New Patients" tab.**

Dental Insurance Information

Primary Insurance

Name of Insured _____Insured's DOB___/____/____

Soc. Security# _____ Relationship to patient_____

Are you a F/T Student? YES/NO If Yes, where do you attend?_____

Insured's Employer_____

Insurance Co Name _____Address_____

Group #_____ Patient ID #_____

Secondary Insurance

Name of Insured _____Insured's DOB___/____/____

Soc. Security#_____ Relationship to patient_____

Are you a F/T Student? YES/NO If Yes, where do you attend?_____

Insured's Employer_____

Insurance Co Name _____Address_____

Group #_____ Patient ID #_____

Please bring your insurance card with you to your appointment.

Welcome! So that we may provide you with the best possible care, please complete both pages of this Medical/Dental history form.
All information is completely confidential.

What is the reason for your visit? _____

When was the last time you have had your teeth cleaned? _____

When were your last dental x-rays taken and what kind? Full mouth series (18 x-rays) _____
Panorex _____ *Bitewings* _____

Have you had previous periodontal treatments?
YES NO When? _____

Do your gums bleed? YES NO
When you brush? YES NO

Have you noticed any loose teeth? YES NO
Shifting teeth? YES NO

Have you noticed any mouth odors or bad tastes?
YES NO For how long?_____

Have you had your teeth straightened?
YES NO When? _____

Do you often have fever blisters on your lips? YES NO
After dental work? YES NO

Are your teeth sensitive to heat, cold, or sweets?
YES NO Which ones?_____

Do foods wedge between your teeth? YES NO

How often do you brush your teeth? _____
Floss?_____

Have you ever smoked? YES NO
What and how much? _____

Have you had any of the following dental treatments?
Please circle

Crowns/Bridges	Root Canal Treatment
Partial Dentures	Dentures
Orthodontics (braces)	Wisdom Tooth Extraction
Implants	

Are you satisfied with the appearance of your teeth?
YES NO
If no, what would you like to change about your smile?

_____

Are you aware of grinding your teeth at night in your sleep? YES NO

Are you aware of holding your teeth together?
YES NO

In your jaw joints, do you have clicking?_____
popping? _____ or pain? _____

Do you have headaches regularly? YES NO
Morning?_____ Evening? _____
After eating? _____

Have you ever had an extremely frightening experience with dentistry? YES NO

Confidentiality will be maintained: If you have used drugs in the past or are currently using drugs, please discuss this with Dr. Smith. Failure to do so could jeopardize your life.

Have you ever taken prednisone or cortisone?
YES NO
If yes, when and for how long?_____

_____

Have you ever taken anticoagulants (blood thinners)?
YES NO
If yes, when and for how long?_____

_____

Have you ever been treated for Multiple Myeloma. Metastic Cancer, Paget's Disease, or Osteoperosis?
YES NO
If yes:_____

Is there any medical or dental problem that you would like to discuss with the doctor in confidentiality? YES NO

Have we treated any of your family or friends?
YES NO
If yes, who?_____

 Thank you for filling out your information before your appointment!

Got Smile Dental Group Medical History Form

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? If so, please list physician's name.	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Are you experiencing pain from your mouth at this time?	◯ Yes ◯ No	
Do you feel you are currently in good dental health?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other

Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Shortnes of Breath ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	STD ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker/Defib ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Tire Easily ◯ Yes ◯ No	Apnea ◯ Yes ◯ No	Family History of Diabetes ◯ Yes ◯ No	Immunodefiency ◯ Yes ◯ No
C.Diff.Colitis ◯ Yes ◯ No	History of periodontal disease ◯ Yes ◯ No	Bleeding gums ◯ Yes ◯ No	Shifting teeth ◯ Yes ◯ No
Mouth odors or bad tastes ◯ Yes ◯ No		History of fever blisters ◯ Yes ◯ No	Sensitive teeth (to hot, cold or sweets) ◯ Yes ◯ No
History of grinding or clenching teeth ◯ Yes ◯ No	Orthodontics (teeth straightening) ◯ Yes ◯ No	History of frightening dental visits ◯ Yes ◯ No	
	Clicking or popping in your jaw joint(s) ◯ Yes ◯ No		

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Have you ever had a joint replacement?	◯ Yes ◯ No	If yes
Do you require Premedication for dental visits?	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____