Welcome to Elite Smiles Dental!

Name: Date of Birth: Address: Social Security #: Home Phone #: Cell Phone #: Age: Sex: Marital Status: Cell Phone #: E-mail: (will only be used for office communications) If you were referred to our office by a current patient outside of your immediate family, our CARE TO SHARE program allows you both to earn a \$25 credit on both of your accounts! Whom may we thank for referring you? RESPONSIBLE PARTY/EMERGENCY CONTACT INFORMATION Name: Date of Birth: Address: Social Security #:	DAMIENA INFORMATION	
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Family/Single coverage:		Union or Local #: Group #:
	Insurance Co:	Union or Local #: Group #: Phone #:

Welcome to Elite Smiles Dental!

PATIENT MEDICAL HISTORY

Primary Care Physician:		Phone #:		Date of Last Exam:		
Have you ever been told you have one of the following? Check only if answer is yes.						
Heart Disease	Anemia	Asthma	Heart Murmur	Congenital Heart Defect		
Bleeds Easily	Swollen Ankles	Heart Attack	Shortness of Breath	Joint Replacement/Implant		
Fainting/Seizures	Swollen Ankles	Arthritis	Chest Pain - Angina	Sexually Transmitted Disease		
Hay Fever/Allergies	Emphysema	Cancer	Epilepsy/Convulsions	Psychiatric Treatment		
Kidney Disease	Rheumatic Fever	Diabetes	High Blood Pressure	Radiation Therapy		
Liver Disease:	Stomach Ulcer	Stroke	Low Blood Pressure	Mitral Valve Prolapse		
Hepatitis	Thyroid Disease	Glaucoma	Leukemia	AIDS/HIV		
Jaundice	Other:					
Do you have any allergies to any medications?						
Are you under any medical treatment now? Please explain: Have you ever had any other serious illness not listed above? Please explain: Are you currently taking any medications? Please explain: Have you ever had a bad reaction to local anesthetic or penicillin? Please explain: Do you use tobacco? Please explain: Do you use tobacco? Please explain: Do you use alcohol, cocaine, or other drugs? Please explain: For women only: Are you pregnant or think you may be pregnant? What month: For women only: Are you currently taking birth control pills?						
		Date	of Last Exam.			
Name of Previous Dentist: Date of Last Exam: Location: Date of Last Cleaning:						
What is the reason for you						
Do you have any pain or discomfort now? Please explain:						
Do your gums bleed? Have you ever had surgery performed on your gums?						
Have you ever worn braces? Do you wear Dentures?						
Do you clench or grind your teeth? Have you ever had any trauma to your face or mouth?						
Do you floss? How often? How many times per day you brush your teeth?						
Are your teeth sensitive to hot or cold liquids? Are your teeth sensitive to sweet or sour liquids/foods?						
Do you have any sores or lumps in or around your mouth? Do you like your smile?						
Have you ever had prolonged bleeding after extractions? Do you bite your lips or cheeks frequently?						

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

Signature of Patient/Parent or Guardian

Doctor's Comments:

Date

Signature and Date: