

# Healthy Smile Dentistry, LLC.

*Healthy Smiles Start Here*

## Patient Insurance Information

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Patient ID #

### PERSONAL INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work): \_\_\_\_\_

(Cell) \_\_\_\_\_ e-mail: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Primary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

*I understand that payment is my obligation regardless of insurance or any other third-party involvement.*

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# Patient **Medical** Information

Patient ID #

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Patient Name: \_\_\_\_\_ Initial Date: \_\_\_\_\_

Update (1): \_\_\_\_\_ Update (2): \_\_\_\_\_

## HEALTH INFORMATION

Personal Physician Name: \_\_\_\_\_

Personal Physician Address: \_\_\_\_\_

YES NO

- 1. Have you been hospitalized within the past 2 years? For what? \_\_\_\_\_
- 2. Are you currently being treated by a physician? For what? \_\_\_\_\_
- 3. Are you currently taking any medicines or drugs? What? \_\_\_\_\_
- 4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
- 5. Are you allergic to any drugs? What? \_\_\_\_\_
- 6. Are you allergic to any metals? What? \_\_\_\_\_
- 7. Have you ever had a skin rash or other reaction to metal jewelry? To What? \_\_\_\_\_
- 8. Do you bleed excessively upon injury?
- 9. Are you pregnant?
- 10. Have you ever been involved with dental/medical legal activity?
- 11. Do you smoke? How much/often? \_\_\_\_\_

CIRCLE ANY OF THE FOLLOWING **MEDICAL CONDITIONS** THAT YOU HAVE HAD

- |                        |                                      |                            |
|------------------------|--------------------------------------|----------------------------|
| AIDS                   | Arthritis                            | Asthma                     |
| Cancer                 | Diabetes                             | Epilepsy                   |
| Glaucoma               | Heart Murmur                         | Stroke                     |
| Tuberculosis           | Hepatitis/Jaundice                   | Kidney Problems            |
| Low Blood Pressure     | Nervous Breakdown                    | Psychiatric Therapy        |
| Rheumatic Fever        | Sexually Transmitted Disease         | High Blood Pressure        |
| Fainting/Seizures      | Thyroid Problems                     | Cardiac Pace Maker         |
| Angina                 | Anemia                               | Joint Replacement/implants |
| Mitral valve prolapse  | Respiratory Problems                 | Heart problem (_____)      |
| Other Diseases (_____) | <b><i>Continued on Next page</i></b> |                            |

# Patient Dental Information

Patient ID #

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Name of Previous Dentist: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

Previous Dentist's Location: \_\_\_\_\_ date Of Last Cleaning: \_\_\_\_\_

YES NO

- 1. Do your gums bleed while brushing or flossing?
- 2. Are your teeth sensitive to hot or cold liquids/foods?
- 3. Are your teeth sensitive to sweet or sour liquids/foods?
- 4. Do you feel pain in any of your teeth?
- 5. Do you have sores or lumps in you mouth?
- 6. Have you had any head, neck or jaw injuries?
- 7. Have you ever experienced any of the following problems in your jaw?
  - a. clicking
  - b. Pain (joint, ear side of face)?
  - c. Difficulty in opening or closing you jaw?
  - d. Difficulty in chewing?
- 8. Do you have frequent headaches?
- 9. Do you clench or grind your teeth?
- 10. Do you bite your lips or cheeks frequently?
- 11. Have you ever had any difficult teeth extractions in the past?
- 12. Have you ever had prolonged bleeding following tooth extraction?
- 13. Have you had any orthodontic treatment?
- 14. Do you wear dentures or partials? If yes, Date of placement: \_\_\_\_\_.
- 15. Have you ever received oral hygiene instruction regarding the care of your teeth and gums?
- 16. Do you like your smile?

## Authorization and Release

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 Healthy Smile Dentistry, LLC and the Dentist: Dr. Sahar Hamzeh, 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 or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (or parent/guardian if minor)

Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_