HollidaySmiles
DENTISTRY

Today's Date _____

Name of Patient _____ Preferred Name _____ Sex: M F

Birthdate _____ Age _____ SSN _____ Marital Status _____

Mailing Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell _____E-mail address _____

Please circle the ways may we contact you: e-mail cell phone work phone home phone May we text you? YES NO

Patient Employed by _____ Occupation_____ Work Phone _____

Name of Spouse, Parent, or Responsible Party(If patient is under 18) _____

Address of Spouse, Parent, or Responsible Party_____ DOB_____SSN_____

In case of emergency, who should be notified:_____Cell_____ Relationship _____

Purpose of today's appointment_____

INSURANCE INFORMATION

Do you have dental insurance? Yes ___ No ___ If yes, name of company _____

Name of policy holder_____ Policy holder's SSN/ID _____ Birthdate _____

Policy holder's employer _____ Phone _____

Do you have secondary dental insurance? Yes ___ No ___ If yes, name of company _____

Name of policy holder_____ Policy holder's SSN/ID _____ Birthdate _____

Policy holder's employer _____ Phone _____

Please take your insurance card to our front desk for duplication and verification.

MEDICAL HISTORY

Have you ever had any of the following? Please circle "yes " or "no" for each condition and add details when response is "yes".

No ADD or ADHD Yes, Details _____
No AIDS/HIV Yes, Details _____
No Alzheimer's/dementia Yes, Details _____
No Arthritis Yes, Details_____
No Autism Yes, Details_____
No Blood Disorders Yes, Details_____
No Blood Pressure Problems Yes, Details _____
No Blood-thinning Medication Yes, Name _____
No Blood Transfusion Yes, Details _____
No Cancer Yes, Details_____
No Chemotherapy Yes, Details _____
No Diabetes Yes, Type _____
No Drug Abuse Yes, Details _____
No Dry Mouth Yes, Details_____
No Epilepsy Yes, Details_____
No Gastric Ulcers Yes, Details_____
No Glaucoma Yes, Details_____
No Heart Murmur Yes, Details_____
No Heart Valve Replacement Yes, Details_____
No Dizziness of Fainting Yes, Details_____

No Dental Anxiety/Fear Yes, Details _____
No Hepatitis/Liver Disease Yes, Details_____
No Heart Disease/surgery Yes, Details_____
No Hemophilia Yes, Details_____
No Taken Bisphosphonates Yes, Details _____
No Herpes/Fever Blisters Yes, Details_____
No Joint Replacement Yes, Details_____
No Kidney Disease Yes, Details_____
No Latex Allergy Yes, Details_____
No Mitral Valve Prolapse Yes, Details_____
No Osteoporosis Yes, Details_____
No Pacemaker Yes, Details _____
No Parkinson's Disease Yes, Details _____
No Pregnant or Nursing Yes, Due Date _____
No Radiation Treatment Yes, Details_____
No Rheumatic Fever Yes, Details_____
No Stroke Yes, Details_____
No STD Yes, Type _____
No Tobacco Products use Yes, Types _____
No Tuberculosis Yes, Details _____

PLEASE CONTINUE TO THE REVERSE SIDE

MEDICAL HISTORY

List medications to which you have reaction or are allergic: _____

_____

List medications you are currently taking: _____

_____

Name of Physician: _____ Phone_____

What pharmacy do you prefer?_____ Location_____ Phone_____

Other medical conditions or surgeries? _____

Have you ever had problems with local anesthesia (numbing your teeth)? Yes _____ No _____ Details _____

Have you had serious problems associated with dental treatment? Yes _____ No _____ Details _____

Please indicate special needs: Wheelchair Neck pillow Back pillow Blanket Walking assistance Other: _____

Please inform us of the persons with whom we may share your health/dental /financial information :

Name: _____ Phone _____ Relationship _____

Name: _____ Phone _____ Relationship _____

Please share how you heard about our practice? Sign Internet Publication Person Other:_____

If a person referred you, please share their name so we can thank them: _____

I, THE UNDERSIGNED, CERTIFY I UNDERSTAND AND AGREE TO THE FOLLOWING:

- I assign all third party payments to this practice.
- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other healthcare providers and institutions.
- I acknowledge that I have received a copy of the practice's Notice of Privacy Practices.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.
- I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage.
- I assume responsibility for all costs of collections, including collection agency fees, finance charges, attorney fees, court costs, and other such related fees.
- I understand that dental insurance companies rarely cover 100% of dental expenses.
- I understand exactly how my insurance company will pay for services rendered at this practice. If not, ask us to find out for you.
- I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized with the office 48 hours prior to the appointment or a late cancellation fee may be charged.
- I have accurately answered all the questions and have read and understand all the above information.
- I give consent for this practice to photograph any tissue, bone, or anatomical structures for purposes of diagnosis, treatment, patient education, presentation, or medical/dental research. I understand that any photographs or xrays taken in this office may include identifiable facial characteristics.
- I understand the success of any dental treatment is dependent on proper dental care at home and regular preventive appointments in the practice.
- I authorize this practice to perform appropriate procedures and services in order to diagnose and treat my oral health condition.

Signature: _____ Relationship to Patient: _____

Print name: _____ Date Signed: _____