# PATIENT INFORMATION

**Patient Name:** ______________________________ **Birth Date:** ______________________
LAST FIRST MI

☐ **Male** ☐ **Female** **Status: Married** ☐ **Single** ☐ **Child** ☐

**Social Security #:** ______________________________ **Driver's Lic #:** ______________________

**Home Phone:** ____________ **Cell Phone:** ____________ **Work Phone:** ______________________

**Mailing Address:** ____________________________________________________________
STREET / PO BOX APT. or UNIT #

____________________________________________________________
CITY STATE ZIP CODE

**E-mail Address:** ____________________________________________________________

**Who may we thank for referring you? Family/ Friend Name:** ____________________**Other: Check all that apply!**
☐ **Google Search** ☐ **Google Maps** ☐ **Bing** ☐ **Facebook** ☐ **Instagram** ☐ **Yelp** ☐ **Insurance Co.** ☐ **Website**

---

## Responsible Party Information

**Name:** ______________________________ **Birth Date:** ______________________
LAST FIRST MI

**Social Security #:** ______________________________ **Driver's Lic #:** ______________________

**Home Phone:** ____________ **Cell Phone:** ____________ **Work Phone:** ______________________

**E-mail Address:** ____________________________________________________________

## Dental Insurance Information

| | PRIMARY DENTAL INSURANCE | SECONDARY DENTAL INSURANCE |
|---|---|---|
| NAME OF INSURANCE Co.: | ____________ | ____________ |
| INSURANCE CO. PHONE #: | ____________ | ____________ |
| GROUP NUMBER: | ____________ | ____________ |
| ID / POLICY NUMBER: | ____________ | ____________ |
| SUBSCRIBERS NAME: | ____________ | ____________ |
| SUBSCRIBERS DOB: | ____________ | ____________ |

I authorize the use of any information necessary to process my insurance. I also authorize my insurance company(s) to issue the dental benefits of my plan directly to this office.

***SIGNATURE OF RESPONSIBLE PARTY:*** ______________________________ ***DATE:*** ____________

***DOCTOR SIGNATURE:*** ______________________________ ***DATE:*** ____________

# ALASKA SMILES

## MEDICAL / DENTAL HISTORY

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________________________

- Are you under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:______________________ Name of Physician:______________

- Please list any current medication you are taking: ______________________________

- Is there any other medical or dental information you feel I should know about? ☐ Yes ☐ No
  If yes please explain:______________________________________________

**Please check the following that apply to you:**

- ☐ **Sensitivity (hot, cold, sweet)**
  **Where:** ____________
- ☐ **Headaches, neck or jaw joint pain**
- ☐ **Mouth ulcers or cold sores**
- ☐ **Grinding or clenching**
- ☐ **Bleeding swollen or irritated gums**
- ☐ **Loose, chipped or shifting teeth**

**If you could change your smile would you:**

- ☐ **Whiten your teeth**
- ☐ **Straighten your teeth**
- ☐ **Close Spaces**
- ☐ **Replace silver-metal fillings with tooth colored fillings**
- ☐ **Repair chipped teeth**
- ☐ **Replace missing teeth**
- ☐ **Replace old crowns that don't match**
- ☐ **Have a smile makeover**

**Do you have or have you had any of the following:**

- ☐ **Full or partial dentures**
- ☐ **Braces**
- ☐ **Periodontal gum treatments**

**Have you had a fever, cough, or shortness of breath in the last 24 hours?** ☐ **Yes** ☐ **No**

**Do you smoke or chew tobacco?** ☐ **Yes** ☐ **No**

How much?_______ For how long?________

**Is keeping your teeth important to you?** ☐ **Yes** ☐ **No**

**Why did you leave your last dentist?** ______________

**On a scale of 1 – 10, with 10 the highest rating:**

How important is your dental health to you?

**1 2 3 4 5 6 7 8 9 10**

Where would you rate your current dental health?

**1 2 3 4 5 6 7 8 9 10**

**What is the most important thing to you about your future smile and dental health?** ______________________

**What is the most important thing to you about your dental visit today?**______________________

## HEALTH INFORMATION

- ☐ AIDS / HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Artificial Heart Valve
- ☐ Bruise Easily
- ☐ Blood Disease
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Fainting /Dizziness/ or Blackouts
- ☐ Epilepsy or Seizure
- ☐ Facial/Head Injuries
- ☐ Glaucoma/ Eye Problems
- ☐ Hay fever
- ☐ Excessive Bleeding
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Heart Disease or Attack
- ☐ Hepatitis A / B / C
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Nervous / Mental Disorders
- ☐ Nerve Disorder
- ☐ Orthopedic Pins
- ☐ Psychiatric Treatment
- ☐ Pregnant Now
  Due Date:________
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumors

ALLERGIES:

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Other:__________
- ☐ PREMED Yes /No

***SIGNATURE OF RESPONSIBLE PARTY:***______________________________ ***DATE:***____________

***DOCTOR SIGNATURE:*** ______________________________ ***DATE:***____________

***SIGNATURE OF RESPONSIBLE PARTY:*** ________________________________________ ***DATE:*** _______________

***DOCTOR SIGNATURE:*** ________________________________________________________ ***DATE:*** _______________