Smiles by Design **57 Bedford Street, Lexington, MA 02420** **Telephone: (781) 674-9995**

PATIENT INFORMATION

Check all that apply: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. AND ☐ Married ☐ Single AND ☐ Male ☐ Female AND ☐ Minor

Name_____
Last Name First Name MI Nickname (if applicable)

Address _____
Street Apt. City State Zip Code

Birth Date _____ Social Security # _____/_____/_____ Home Telephone #_____
Month/Day/Year

E-Mail Address_____Cell Phone_____

Place of Employment_____ Work Telephone #_____

Dental Insurance Co.:_____ Subscriber # _____

Address _____ Telephone # _____

Has any member of your family ever been treated in our office? ☐ Yes ☐ No

Whom may we thank for referring you: ☐ Internet Search via Google/Yahoo/AOL/Other_____
☐ Telephone Book_____ ☐ Patient _____ ☐ Cheesecake Factory ☐ Other_____

FAMILY INFORMATION

HUSBAND (If patient is married)
FATHER (If patient is a minor)

_____
Last Name First Name MI

_____
Address, if different than above State Zip Code

_____
Home Telephone # Work Telephone #

_____
Birth Date (Month/Day/Year) SS#

_____
Employer Position

_____
Dental Insurance Co. Subscriber # Group #

_____
Address

WIFE (If patient is married)
MOTHER (If patient is a minor)

_____
Last Name First Name MI

_____
Address, if different than above State Zip Code

_____
Home Telephone # Work Telephone #

_____
Birth Date (Month/Day/Year) SS#

_____
Employer Position

_____
Dental Insurance Co. Subscriber # Group #

_____
Address

PERSON TO CONTACT IN EMERGENCY

Nearest relative not living with you

Name _____ Relationship_____

Address _____ Telephone #_____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professionals.

X_____
☐ Adult Patient ☐ Father ☐ Mother ☐ Husband ☐ Wife ☐ Guardian

Date _____

HIPPA ACKNOWLEDGEMENT

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

X_____
Signature Date

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Patient refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other _____

HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit

_____

Name of Dentist Last Seen_____ Date of Last Dental Care _____ Date of Last Dental X-rays_____

Mark (X) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sores or growths in mouth
- ☐ Sensitivity to hot
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting

How often do you brush?_____ How often do you floss?_____

What priority do you give your teeth (10 being the highest)? 1 2 3 4 5 6 7 8 9 10
Are you happy with the way your teeth and smile look? ☐ Yes ☐ No
Is there anything you would like different about your teeth or smile? _____
_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Mark (X) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

Describe_____

- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling/Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List all medications you are currently taking: _____

_____

_____

Pharmacy_____Telephone #_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Local Anesthetic
- ☐ Other _____
- ☐ I have no allergies
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa

SIGNATURE

To the best of my knowledge the above health history is true and correct.
Signature_____
Date_____