

## PATIENT INFORMATION (please print)

### PERSONAL

Reason for your visit: \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_ Preferred Name: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Sex:  M  F Married:  Yes  No E-mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Please provide Photo I.D. (i.e. Driver's License) Would you like to receive a text reminder?  Y  N

Social Security #: \_\_\_\_\_ Student Status if dependent over 19  Nonstudent  Fulltime  Part-time

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_ Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex:  M  F Relationship: \_\_\_\_\_ Employer: \_\_\_\_\_

### INSURANCE POLICY 1

Under whose name is your insurance? \_\_\_\_\_ Relationship:  Self  Spouse  Child

SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Insured ID Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group No.: \_\_\_\_\_

### INSURANCE POLICY 2

Under whose name is your insurance? \_\_\_\_\_ Relationship:  Self  Spouse  Child

SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Insured ID Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group No.: \_\_\_\_\_

#### **Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Healthy Smiles all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian

\_\_\_\_\_  
Name of Patient, Parent or Guardian

\_\_\_\_\_  
Date

# HEALTH HISTORY

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Physician \_\_\_\_\_ Physician's specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**

	Yes	No		Yes	No		Yes	No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>	Gastric/ Eating Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial/Repaired Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Head or Neck Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Abnormally	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash/Hives	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Breathing or Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet/Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Infective Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck/Glands	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Viral Infection	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Cough, Persistent Blood	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease/STD/HPV	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Measles/ Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, severe	<input type="checkbox"/>	<input type="checkbox"/>

Presently being treated for any other illness  Yes  No \_\_\_\_\_

Any change in your health in the last 24 hours  Yes  No Do you wear contact lenses?  Yes  No

Taking Birth Control?  Yes  No Are you pregnant?  Yes  No

Are you nursing?  Yes  No Taking dietary supplements  Yes  No

Taking medication for weight management  Yes  No

Tobacco Use -  Smoking  Chewing  Holding in vestibule Quantity Used in 24 Hrs \_\_\_\_\_

Have you taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)  Yes  No

**MEDICATIONS**

List any medications you are currently taking.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES**

Aspirin Penicillin Latex  
 Erythromycin Tetracycline Sulfa  
 Fluoride Iodine Codeine  
 Barbiturates (sleeping pills) Local Anesthetic  
 Metal (nickel, gold, silver,) Fruit/Nuts  
 Other \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_