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	☐	☐	Emphysema/Pneumonia	☐	☐	Nervous Problems	☐	☐
Anemia	☐	☐	Epilepsy/Seizure	☐	☐	Pacemaker	☐	☐
Alcohol/Recreational Drugs	☐	☐	Fainting or Dizziness	☐	☐	Prostate Disorder	☐	☐
Antidepressant medication	☐	☐	Gastric/ Eating Disease	☐	☐	Psychiatric Care	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Radiation Treatment	☐	☐
Artificial/Repaired Heart Valve	☐	☐	Head or Neck Injuries	☐	☐	Respiratory Disease	☐	☐
Artificial Joints	☐	☐	Headaches	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Scarlet Fever	☐	☐
Autoimmune Disease	☐	☐	Heart Problems	☐	☐	Shortness of breath	☐	☐
Back Problems	☐	☐	Hepatitis	☐	☐	Sinus Trouble	☐	☐
Bleeding Abnormally	☐	☐	Herpes	☐	☐	Skin Rash/Hives	☐	☐
Blood Disease	☐	☐	High Cholesterol	☐	☐	Special Diet	☐	☐
Breathing or Sleep Problems	☐	☐	High Blood Pressure	☐	☐	Stroke / Blood Thinners	☐	☐
Cancer	☐	☐	Hormone Deficiency	☐	☐	Swollen Feet/Ankles	☐	☐
Chemical Dependency	☐	☐	Infective Endocarditis	☐	☐	Swollen Neck/Glands	☐	☐
Chemotherapy	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Circulatory Problems	☐	☐	Jaw Pain	☐	☐	Tonsillitis	☐	☐
Cold Sores/Viral Infection	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesion	☐	☐	Liver Disease	☐	☐	Tumors	☐	☐
Cortisone Treatments	☐	☐	Low Blood Pressure	☐	☐	Ulcer	☐	☐
Cough, Persistent Blood	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease/STD/HPV	☐	☐
Diabetes	☐	☐	Measles/ Chicken Pox	☐	☐	Weight Loss, severe	☐	☐

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**_____