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Welcome

Patient Information

Date: _____ SS/HIC/ Patient ID#: _____

Patient Name: _____

Last

First

Middle

Address: _____ City: _____ State: _____

Zip: _____ E-Mail: _____

Sex: M ___ F ___ Age: _____ Birthdate: _____

Married: ___ Widowed: ___ Single: ___ Minor: ___ Separated: ___ Divorced: ___

Partnered for ___ years Occupation: _____ Patient Employer/School: _____

Employer/School Address: _____

Employer/School Phone: _____

Spouse's Name: _____ Birthdate: _____ SS# _____

Spouse's Employer: _____ Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Co. _____ Group # _____

Is patient covered by additional Insurance? _____ Subscribers Name: _____

Birthdate: _____ SS# _____ Relationship to Patient: _____

Insurance Company: _____ Group#: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me 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 dentist may use my health care 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 the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative

Please Print name of Patient, Parent, Guardian, or Personal Representative

Date

Relationship to Patient

Phone Numbers

Home: (____) _____ Work: (____) _____ Ext _____

Cell Phone(____) _____ Spouse's Work:(____) _____

Best time and place to reach you: _____

In Case of Emergency, Contact (Specify someone who does not live in your household.)

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____

Dental History

Reason for today's visit _____ Former dentist: _____

City/State: _____

Date of last dental visit _____ Date of last dental X-Rays _____

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

Put an "X" next to those that apply to your health:

Bad Breath: _____ Bleeding Gums: _____ Blisters on lips or mouth: _____ Burning sensation on tongue: _____

Chew on one side of mouth: _____ Cigarette, pipe, or cigar smoking: _____ Clicking or popping jaw: _____

Dry Mouth: _____ Fingernail biting: _____ Food collection between teeth: _____ Foreign objects: _____

Grinding teeth: _____ Gums Swollen or tender: _____ Jaw pain or tiredness: _____ Lip or Cheek biting: _____

Loose teeth or broken fillings: _____ Mouth breathing: _____ Mouth pain, brushing: _____

Orthodontic Treatment: _____ Pain around Ear: _____ Periodontal Treatment: _____ Sensitivity to cold: _____

Sensitivity to hot: _____ Sensitivity to sweets: _____ Sensitivity when biting: _____

Sores or growths in your mouth: _____

Health History

Physician's Name: _____ Date of last visit: _____

Have you ever 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 _____

Place an "X" to indicate if you have had any of the following:

AIDS/HIV: _____ Anemia: _____ Arthritis, Rheumatism: _____ Artificial Heart Valves: _____

Artificial Joints: _____ Asthma: _____ Back Problems: _____ Blood Disease: _____ Cancer: _____

Bleeding abnormally, with extractions or surgery: _____ Chemical Dependency: _____

Chemotherapy: _____ Circulatory Problems: _____ Congenital Heart Lesions: _____ Cortisone Treatments: _____

Cough, persistent or bloody: _____ Diabetes: _____ Emphysema: _____ Epilepsy: _____

Fainting or dizziness: _____ Glaucoma: _____ Headaches: _____ Heart Murmur: _____ Heart Problems: _____

Hepatitis Type: _____ Herpes: _____ High Blood Pressure: _____ Jaundice: _____ Jaw Pain: _____

Kidney Disease: _____ Liver Disease: _____ Low Blood Pressure: _____ Mitral Valve Prolapse: _____

Nervous Problems: _____ Pacemaker: _____ Psychiatric Care: _____ Radiation Treatment: _____

Respiratory Disease: _____ Rheumatic Fever: _____ Scarlet Fever: _____ Shortness of Breath: _____

Sinus Trouble: _____ Skin Rash: _____ Special Diet: _____ Stroke: _____ Swollen Feet or Ankles: _____

Swollen Neck Glands: _____ Thyroid Problems: _____ Tonsillitis: _____ Tuberculosis: _____

Tumor or growth on head or neck: _____ Ulcer: _____ Venereal Disease: _____

Weight Loss, unexplained: _____ Do you wear contact lenses? _____

Woman:

Are you pregnant? _____ Due Date: _____ Are you nursing? _____

Taking Birth Control Pills? _____

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name: _____ Phone Number: _____

Allergies

Asprin: _____ Local Anesthetic: _____ Barbiturates (Sleeping Pills): _____

Penicillin: _____ Codeine: _____ Sulfa: _____ Iodine: _____

Latex: _____ Peanut: _____ Other: _____