Welcome to Smyrna Dental Center
Dr. Greg Downer

PATIENT INFORMATION

Patient Name: ____ Date: ______________
Last First MI

Preferred Name: ______________________ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other _______

Date of Birth: ____/____/____ Social Security # ______/______/______

E-mail Address: ______________________________ @ ________________________

May we text and / or e-mail you regarding your appointments ❑ Yes ❑ No

Phone: Home: __________________ Cell: __________________ Work: __________________

Address: ____
Street Apt #

____
City State Zip

Emergency Contact: Name: ________________________ Relationship: ______________ Phone: ______________

DENTAL INSURANCE

Person Responsible For Account ____

Relation to Patient __________________ Birthdate ________________________ SS# ______________________

Address (if different from patients) ________________________________ Phone: ______________________

Employer ____ Work Phone # ______________________

Insurance Company __________________ Contact# ____________________ Group# ______________________

Subscriber # (if different than SS#) ____________________ Do you have other dental Insurance? ______________

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for service rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am responsible for all charges whether or not paid by insurance.

All co-pays must be paid at time of service.

Signature ____ Date ______________________________

How did you hear about us?

❑ Internet / Website ❑ Friend / Existing Patient ❑ Another Dental Office

❑ Direct Mail Post Card ❑ Insurance

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Name of person or dental office whom we may thank for referral.

MEDICAL HISTORY

Physicians Name ______________________ Date of Last Visit ______________

Do you require an antibiotic before dental treatment? ❑ Yes ❑ No

Have you had any serious illness or operations: ❑ Yes ❑ No If Yes, Please Describe below ______________

Have you ever had a blood transfusion? ❑ Yes ❑ No If Yes, Approximate Date(s) ______________

Are You Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills ❑ Yes ❑ No

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS	Cough Persistent	High Blood Pressure	Skin Rash
Anemia	Cough up Blood	HIV Positive	Stomach Problems
Arthritis	Diabetes	Jaw Pain	Stroke
Asthma	Epilepsy	Kidney Disease	Swelling or Feet of Ankles
Back Problems	Fainting	Liver Disease	Thyroid Problems
Cancer	Glaucoma	Nervous Problems	Tobacco Habit
Chemical Dependency	Headache	Radiation Treatment	Tuberculosis
Circulatory Problems	Heart Problems	Respiratory Disease	Ulcer
Cortisone Treatment	Hemophilia	Rheumatic Fever	Venereal Disease
	Hepatitis	Shortness of Breath	Any Other Conditions not Listed ______________

Have you ever taken an of these medications?

Medication		
Blood Thinners	❑ Yes	❑ No
Coumadin	❑ Yes	❑ No
Warfarin	❑ Yes	❑ No
Diet Medications	❑ Yes	❑ No
Dexfenifluramine	❑ Yes	❑ No
Fan-Phen	❑ Yes	❑ No
Pondimin	❑ Yes	❑ No
Hypothyroid Medications	❑ Yes	❑ No
Levothyroxine	❑ Yes	❑ No
Levoxyl	❑ Yes	❑ No
Synthroid	❑ Yes	❑ No
Hyperthyroid Medications	❑ Yes	❑ No
Methhimazole	❑ Yes	❑ No
Propylthiovracil	❑ Yes	❑ No
Tapazole	❑ Yes	❑ No
Osteoporosis Medications	❑ Yes	❑ No
Bisphosphonates	❑ Yes	❑ No
Fosamax	❑ Yes	❑ No
Boniva	❑ Yes	❑ No
Actonel / Atelvia	❑ Yes	❑ No
Reclast	❑ Yes	❑ No

Have you ever had or been diagnosed with:

Condition		
Artificial Heart Valve	❑ Yes	❑ No
Artificial Joints, Screws, Pins, etc.	❑ Yes	❑ No
Bleeding Abnormally, with extractions or Surgery	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Hernia Repair	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No

Are you Allergic to:

Allergen		
Aspirin	❑ Yes	❑ No
Barbiturates	❑ Yes	❑ No
Codeine	❑ Yes	❑ No
Ibuprofen	❑ Yes	❑ No
Latex	❑ Yes	❑ No
Local Anesthesia	❑ Yes	❑ No
Metals (i.e. gold)	❑ Yes	❑ No
Penicillin	❑ Yes	❑ No

Other ______________
____
____
____

Please list any other medications you are currently taking: ______________
____
____
____

Do you have any health problems that need further explanation?

Please explain: ______________
____
____
____

DENTAL HISTORY

Reason for today's visit: ____

How long since your last dental visit? ______________________ Purpose of last visit: ____________________

How do you feel about your teeth and smile? Circle one Good Fair Poor

Have you had a bad dental experience in the past? ❑ Yes ❑ No

Are you pleased with the dental work you currently have? ❑ Yes ❑ No

Have you had professional gum treatment in the past? ❑ Yes ❑ No

Do your gums bleed when you brush? ❑ Yes ❑ No

Do you want to develop a comprehensive treatment plan for your dental health? ❑ Yes ❑ No

Please circle if you have recently experienced any of the following:

Bad Breath	Grinding Teeth	Sensitivity to Heat
Bleeding Gums	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Clicking or Popping Jaw	Periodontal Treatment	Sensitivity When Biting
Food Collection Between Teeth	Sensitivity to Cold	Sores or Growths in Your Mouth

Have you ever had any complications following dental treatment? ❑ Yes ❑ No

Please Explain ____

____

Please tell us your main dental concerns and / or changes you would like to see with your smile: ____________________

____

____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous. It is my responsibility to inform this office of any changes in my medical status and/or in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered, during the period of such dental care, to third party and/or health practitioners. I also authorize the staff to perform the necessary dental services needed.

Signature of Patient, Parent or Guardian ____