

Newport Smiles



Your general information: _____ Date: _____

Patient Name: _____ SS# _____

Address: _____ City _____ Zip _____

Email: _____ Sex F M Age: _____ Birthdate: _____

Are you: Married Widowed Single Minor Separated Divorced Partnered

Patient Employer/School: _____ Occupation: _____

Phone Numbers:

Home: (____) _____ Work (____) _____ Ext. _____ Cell phone: (____) _____

Who may we thank for referring you: _____

Dental Insurance

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

Insurance Co.: _____ Group #: _____ Subscriber's Name: _____

Is the Patient covered by additional Insurance: Yes No Subscriber's Name: _____

Birthdate: _____ SS#: _____ Relationship to Patient: _____

Insurance Co.: _____ Group #: _____

Assignment and Release

I certify that I, and my dependent(s) have Insurance coverage with _____ and assign directly to: **Newport Smiles** 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 Practice may use my health care information and disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or personal Representative

Date

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

Relationship to Patient

DENTAL HISTORY

Reason for today's visit _____

Do you have any dental problems now? Yes No If yes, please describe _____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Did any previous dentists recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____ Why was this treatment never performed? _____

Do you feel nervous about dental treatment? Yes No

Ever had an upsetting dental experience? Yes No If so, please describe _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Rotodent, Interplak, toothpick, etc.) _____

Please circle the following dental values most important to you and underline the least important:

Esthetics

Com fort

Longevity

Function

Long-term cost effectiveness

Please circle the most important feature(s) in your smile that you would like to change?

Color

Shape

Alignment

Length

Gaps

Gum display

Nothing, I'm happy.

Other _____

Would you like your smile analyzed? Yes No If yes, is there a spouse or significant other you want to include in our discussion? Yes No

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Noticed any mouth odors or bad tastes? Yes No

Do you get cold sores, blisters or other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents had gum disease or tooth loss? Yes No

Noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught between any teeth? ... Yes No

If yes, where _____

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty chewing on either side of mouth? Yes No

Headaches, neck aches, or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Do you:

Clench/grind teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

MEDICAL HISTORY

Indicate which of the following you have had, or have at present:

Tuberculosis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (infectious) B (serum).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Ankles.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex Sensitivity.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diet (Special Restricted).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV positive.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies/Hives.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints (hip, knee).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores/Fever Blisters.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Trouble.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart (Surgery/Disease/Attack).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Lenses.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorders.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous/Anxious.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric (Psychological care).....	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you been under the care of a medical doctor during the past 2 years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Have you been a patient in the hospital during the past 5 years? Yes No

Do you have or have you had any disease condition, or problem not listed above? Yes No

If yes, please list: _____

Have you taken any medication/drugs during the past 2 years? Yes No

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

Are you allergic (or adverse reaction) to any medication or substance? Yes No

Aspirin Local Anesthetic Barbiturates (Sleeping pills) Penicillin Codeine
 Sulfa Iodine Latex Other _____

WOMEN ONLY

Are you: pregnant? Yes ____ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be need, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge will be added to any balance over 30 days in the event of default. I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient/Guardian Signature _____ Date _____