

Patient Welcome Form



THE SMILE CENTER

FAMILY DENTISTRY

Patient Information

Adult/Child: _____ Date: _____

Last Name: _____ First Name: _____ MI: _____

Gender (Male/Female): _____ Email: _____ Birthdate: _____

Marital Status (Single/Married/Divorced/Widower): _____

Driver's License #: _____ S.S.# _____

Address: _____ Apt./Condo #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Occupation: _____ Work Phone: _____

When and where are the best times to contact you? _____

Guarantor

if the patient is a minor, do you have legal custody? _____

Relationship to Patient (Spouse/Parent/Tutor/Legal Guardian/Other): _____

Last Name: _____ First Name: _____ MI: _____

Gender (Male/Female): _____ Email: _____ Birthdate: _____

Marital Status (Single/Married/Divorced/Widower): _____

Driver's License #: _____ S.S.# _____

Address: _____ Apt./Condo #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Occupation: _____ Work Phone: _____

When and where are the best times to contact you? _____

Emergency Contact

in case of emergency please provide the following information:

Name: _____ Relationship: _____

Work Phone: _____ Home/Mobile Phone: _____

How did you hear about us?:

Yellow Pages	Internet	Yelp
Family/Friend	Flyer/Mail	Facebook
Event	Outside Sign/Balloon	Other
Radio	Mobile Ad	
TV	My Insurance Plan	

Payment Options:

Insurance	Unrisa Dental Plan
Cash/ Check	Other
Other	

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Dental History

Why have you come to the dentist today?: _____

Are you currently in pain?(Yes/No): _____

Have you ever had a problem with any previous dental work? (Yes/No): _____

Do your gums bleed? (Yes/No): _____

How many times a week do you brush?: _____

How many times a week do you floss?: _____

Medical History

Personal Physicians Name: _____ Phone Number: _____

Date of Last Visit: _____ Your current health is (Good/Regular/Poor): _____

Are you currently under the care of a physician? (Yes/No): _____

Please explain: _____

Are you taking any prescription/over the counter drugs? (Yes/No): _____

Please list each one: _____

Do you smoke tobacco in any way? (Yes/No): _____

Do you have or have you ever had any of the following?

Please select all that apply:

- | | | | |
|--------------------------------|------------------------|--------------------------|------------------|
| Abnormal Bleeding | Epilepsy | Liver Disease | Thyroid Problems |
| AIDS, HIV+ | Fainting Spells | Low Blood Pressure | Tuberculosis |
| Alcohol or Drug Abuse | Frequent Headaches | Lupus | Ulcers |
| Anemia | Glaucoma | Mitral Valveprolapse | |
| Arthritis | Hay Fever | Pacemaker | |
| Artificial Bones/Joints/Valves | Heart Attack | Psychiatric Problems | |
| Asthma | Heart Surgery | Radiation Treatment | |
| Blood Transfusion | Heart Murmur | Rheumatic; Scarlet Fever | |
| Cancer, Chemotherapy | Hemophilia | Seizures | |
| Colitis | Hepatitis | Shingles | |
| Congenital Heart Defect | Herpes, Fever Blisters | Sickle Cell Disease | |
| Diabetes | High Blook Pressure | Sinus Problems | |
| Difficulty Breathing | Kidney Problems | Stroke | |

Are you allergic to any of the following?

Please select all that apply:

- | | | |
|--------------------|--------------|--------------|
| Aspirin | Penicillin | Jewelry |
| Codeine | Erythromycin | Tetracycline |
| Dental Anesthetics | Latex | |

For women:

Are you taking birth control pills? _____

Are you pregnant?: _____

Week #: _____

Are you nursing?: _____

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Agreement:

I acknowledge that this information is correct and will be held in the strictest confidence.

I authorize The Smile Center to contact me regarding promotions and services.

I authorize The Smile Center to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment directly to The Smile Center of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company. Please type your full first and last name and date to represent your signature. You may also sign this form once you arrive to the office for your appointment.

Signature: _____ Date: _____

Office Use Only:

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____

UPDATE:

Comment: _____

Signature: _____ Date: _____

Comment: _____

Signature: _____ Date: _____