abradental℠
FORMERLY CHILDSMILES•FAMILYSMILES

PATIENT FORM

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

How did you hear about us?

_____

Patient information

First name _____

Last name _____

Middle name _____

DOB _____ Soc. Sec _____

Gender ○ M ○ F Married ○ Yes ○ No

Work phone _____

Cell phone _____

Email address _____

Preferred contact method

○ Work phone ○ Cell phone ○ Email

Address and home phone

Address _____

City _____

State _____

Zip _____

Home phone _____

○ Check box if same for the entire family

Insurance policy 1

Relationship to subscriber

○ Self ○ Spouse ○ Child

Subscriber name _____

Subscriber ID _____

DOB _____

Insurance company _____

Phone _____

Employer _____

No. Group/Name _____

Insurance policy 2

Relationship to subscriber

○ Self ○ Spouse ○ Child

Subscriber name _____

Subscriber ID _____

DOB _____

Insurance company _____

Phone _____

Employer _____

No. Group/Name _____

Dental history

What is the reason for your visit today _____

_____

If this is an emergency, please describe _____

_____

_____

Former/Current dentist _____

Date of last dental visit _____

How often does the patient brush? _____

How often does the patient floss? _____

Does the patient experience pain or discomfort in the jaw joint? ○ Yes ○ No

Has the patient ever experienced a mouth or chin injury? ○ Yes ○ No

Does the patient have speech problems? ○ Yes ○ No

_____

Has the patient ever experienced any unusual reactions to dental injections? ○ Yes ○ No

Do the patient's gums bleed easily? ○ Yes ○ No

Does the patient grind their teeth? ○ Yes ○ No

Other information about the patient's previous dental treatment

_____

_____

Medical history

Patient's physician _____

Phone _____

Date of last visit _____

Is the patient currently under physician care? ○ Yes ○ No

Please list any medical conditions the patient may have including

Asthma ○ Yes ○ No

Bleeding problems ○ Yes ○ No

HIV ○ Yes ○ No

Headaches ○ Yes ○ No

Cancer ○ Yes ○ No

Diabetes ○ Yes ○ No

Sinus trouble ○ Yes ○ No

History of rheumatic fever ○ Yes ○ No

Heart murmur ○ Yes ○ No

Heart trouble ○ Yes ○ No

High blood pressure ○ Yes ○ No

Respiratory disease ○ Yes ○ No

Anemia ○ Yes ○ No

Joint replacment ○ Yes ○ No

Stroke ○ Yes ○ No

Material allergies (latex) ○ Yes ○ No

Kidney disease ○ Yes ○ No

Liver disease ○ Yes ○ No

Epilepsy ○ Yes ○ No

Thyroid disease ○ Yes ○ No

Pregnancy ○ Yes ○ No

Psychiatric treatment ○ Yes ○ No

Ulcers ○ Yes ○ No

Hepatitis ○ Yes ○ No

(Women) Are you pregnant now? ○ Yes ○ No

If yes, how many months? _____

Are you nursing? ○ Yes ○ No

Any additional medical information _____

List any medications patient is taking _____

_____

List drug allergies, if any _____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in the patient's medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services 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 financially responsible for all charges whether or not paid by the insurance company.

Signature _____ Date _____