Welcome

Thank you for selecting DrMarrioSmiles !

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient # _____
SS# _____
Date _____
Patient's Sex ☐F ☐ M

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address_____City _____State _____ Zip _____
Email_____ Cell Phone_____

Do you prefer to receive calls at your: ☐ Home ☐Work ☐Cell Phone

Check Appropriate Box: ☐ Minor ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____City _____St. ____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____Work Phone _____
Business Address _____ City _____ St.____ Zip _____
Spouse or Parent/Guardian's Name _____Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____Phone _____

Responsible Party Name of Person Responsible for this Account _____

Relationship to Patient _____Address _____Home Phone _____
Cell Phone _____Email _____ Driver's License # _____
Birthdate _____ SS#_____
Employer_____ Work Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____SS# _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State ____ Zip _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____SS# SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State ____ Zip _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Co. Address _____ City _____ State _____ Zip _____

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information , including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____
Signature of patient (or parent/guardian if minor) Over Please Date

Patient Medical History

Physician _____ **Office Phone** _____ **Date of Last Exam** _____

	Yes	No
1.Are you under medical treatment now?---------	□	□
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ----------	□	□
3. Are you taking any medication (s) including non-prescription medicine? ----------	□	□

If yes, what medicine (s) are you taking?

_____
_____
_____
_____

4. Have you ever taken Fen-Phen/Redux? ------	□	□
5. Do you use tobacco? ----------	□	□
6. Do you use controlled substances? ----------	□	□
7. Are you wearing contact lenses? ----------	□	□
8. Are your Immunization Shots Update to date	□	□

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain) ----------	□	□
Penicillin or any other Antibiotics ----------	□	□
Sulfa Drugs ----------	□	□
Barbiturates ----------	□	□
Sedatives ----------	□	□
Iodine ----------	□	□
Aspirin ----------	□	□
Any Metals (e.g. nickel, mercury, etc.) ----------	□	□
Latex Rubber ----------	□	□

Other (please list) _____

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ----------	□	□
11. Women Only:		
a) Are you pregnant or think you may be pregnant? --	□	□
b) Are you nursing? ----------	□	□
c) Are you taking oral contraceptives? ----------	□	□

DO YOU HAVE ANY OF THE FOLLOWING

	Yes	No
High Blood Pressure ---------	□	□
Heart Attack ----------	□	□
Rheumatic Fever ------- -------	□	□
Swollen Ankles ----------	□	□
Fainting / Seizures ----------	□	□
Asthma ----------	□	□
Low Blood Pressure ----------	□	□
Epilepsy / Convulsions -------	□	□
Leukemia ----------	□	□
Diabetes ----------	□	□
Kidney Diseases ------- -------	□	□
AIDS or HIV Infection -------	□	□
Thyroid Problem ----------	□	□

	Yes	No
Heart Disease ----------	□	□
Cardiac Pacemaker ----------	□	□
Heart Murmur ----------	□	□
Angina ---- ----------	□	□
Frequently Tired ----------	□	□
Anemia ----------	□	□
Emphysema ----------	□	□
Cancer ----------	□	□
Arthritis ----------	□	□
Joint Replacement or Implant	□	□
Hepatitis / Jaundice ----------	□	□
Sexually Transmitted Disease	□	□
Stomach Troubles / Ulcers -	□	□

	Yes	No
Chest Pains ----------	□	□
Easily Winded ----------	□	□
Stroke ---------- -------	□	□
Hay Fever / Allergies ---------	□	□
Tuberculosis ----------	□	□
Radiation Therapy ----------	□	□
Glaucoma ---------- ----------	□	□
Recent Weight Loss ---------	□	□
Liver Disease ----------	□	□
Heart Trouble ----------	□	□
Respiratory Problems --------	□	□
Mitral Valve Prolapse ------	□	□
Other _____	□	□

Patient Dental History

Name of Previous Dentist and Location _____ **Date of Last Exam** _____

	Yes	No
1. Do your gums bleed while brushing or flossing? ---------	□	□
2. Are your teeth sensitive to hot or cold liquids/foods? ---	□	□
3. Are your teeth sensitive to sweet or sour liquids/foods? --	□	□
4. Do you feel pain to any of your teeth? ----------	□	□
5. Do you have any sores or lumps in or near your mouth?--	□	□
6. Have you had any head, neck or jaw injuries? ----------	□	□
7. Have you ever experienced any of the following problems in your jaw?		
Clicking ----------	□	□
Pain (joint, ear, side of face) ----------	□	□
Difficulty in opening or closing ----------	□	□
Difficulty in chewing ----------	□	□

	Yes	No
8. Do you have frequent headaches? ----------	□	□
9. Do you clench or grind your teeth? ----------	□	□
10. Do you bite your lips or cheeks frequently? ---	□	□
11. Have you ever had any difficult extractions in the past? ----------	□	□
12. Have you ever had any prolonged bleeding following extractions? ----------	□	□
13. Have you had any orthodontic treatment? -----	□	□
14. Do you wear dentures or partials? ----------	□	□
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ----	□	□
16. Do you like your smile? ----------	□	□