PHOENIX
COMPREHENSIVE DENTISTRY

Patient Information

Patient Name:_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Email:_____ ☐Married ☐Single ☐Child

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____

Parent / Guardian Information (If under the age of 18)

Parent/Guardian Name:_____ Relationship to child:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Gender:_____ Age:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Occupation:_____

Work Address:_____ Work Phone:_____

Insurance Information

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Additional Insurance

Primary Insured (Subscriber):_____ Relationship to Patient:_____

Date of Birth:_____ Subscriber ID#:_____

Subscriber Employer or Plan Sponsor:_____ Group#:_____

Insurance Company:_____

Authorization and Release

I authorize my insurance company to pay Smile Today all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** Smile Today may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.

_____

Patient/Parent or Guardian Signature Printed Name Date

Dental History

Reason for today's visit: _____

How often do you brush? _____ How often do you floss? _____

Approx date of last dental visit: _____

Please mark all that apply:

- ☐ TOOTHACHE
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSSING BREAKS OR HURTS
- ☐ PAIN, CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF JAW
- ☐ HEAD ACHES
- ☐ SNORING / SLEEP APNEA

- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ SINUS PROBLEM
- ☐ GAGGING
- ☐ DRY MOUTH
- ☐ DARK OR WHITE SPOTS ON TEETH

- ☐ GUMS
  - ☐ BLEEDING
  - ☐ TENDER OR SORE
- ☐ LOOSE TEETH
- ☐ TEETH HAVE SHIFTED
- ☐ BAD BREATH
- ☐ BAD TASTE IN MOUTH
- ☐ SORES OR GROWTHS IN MOUTH
- ☐ OTHER _____

Medical History

Please mark all that apply:

Have you been: ☐ Hospitalized? ☐ Do You Have Allergies?

Please describe: _____

_____

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	*PRE-MED - AMOX	☐	☐	BIPHOSPHATE MEDS (FosaMax, Acetol, Atelviz, Didronel, Boniva)	☐	☐	HEART DISEASE	☐	☐	PREGNANT
☐	☐	*PRE-MED-CLIND	☐	☐	BLEEDING DISORDERS	☐	☐	HEART MURMUR	☐	☐	RADIATION TREATMENT
☐	☐	*PRE-MED-OTHER _____	☐	☐	BLOOD THINNERS	☐	☐	HEART PROBLEMS	☐	☐	RESPIRATORY PROBLEMS
☐	☐	ALLERGY - ASPIRIN	☐	☐	BLOOD DISEASE	☐	☐	HEMOPHILIA	☐	☐	RHEUMATIC FEVER
☐	☐	ALLERGY - CODEINE	☐	☐	BLOOD TRANSFUSION	☐	☐	HEPATITIS	☐	☐	SCARLET FEVER
☐	☐	ALLERGY - ERYTHRO	☐	☐	CANCER _____	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SHORTNESS OF BREATH
☐	☐	ALLERGY - HAY FEVER	☐	☐	CHEMICAL / DRUG DEPENDENCIES	☐	☐	HIV	☐	☐	STROKE
☐	☐	ALLERGY - LATEX	☐	☐	CHEMO THERAPY	☐	☐	JAUNDICE	☐	☐	SWELLING FEET / ANKLE
☐	☐	ALLERGY - PENICILLIN	☐	☐	CIRCULATORY PROBLEMS	☐	☐	KIDNEY DISEASE	☐	☐	TAKING BIRTH CONTROL
☐	☐	ALLERGY - SULFA	☐	☐	CORTISONE TREATMENT	☐	☐	LIVER DISEASE	☐	☐	THYROID CONDITION
☐	☐	ALLERGY - OTHER _____	☐	☐	DIABETES	☐	☐	MARIJUANA USAGE	☐	☐	TOBACCO USAGE
☐	☐	ANEMIA	☐	☐	DIZZINESS	☐	☐	MENTAL DISORDERS	☐	☐	TONSILLITIS
☐	☐	ARTHRITIS	☐	☐	EPILEPSY	☐	☐	MITRAL VALVE PROLAP	☐	☐	TUBERCULOSIS
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	FAINTING	☐	☐	NERVOUS DISORDERS	☐	☐	ULCERS
☐	☐	ARTIFICIAL JOINTS	☐	☐	GLAUCOMA	☐	☐	NURSING	☐	☐	VENEREAL DISEASE
☐	☐	ASTHMA	☐	☐	HEAD INJURIES	☐	☐	PACEMAKER	☐	☐	OTHER _____
☐	☐	BACK PROBLEMS				☐	☐	PERSISTENT COUGH			

Please list the medications you are currently taking

(including over the counter, supplements, and herbals)

Name	Dosage	Medical Condition

Physicians Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

In Office Use

HEAD & NECK EXAM	WNL or : _____
SOFT TISSUE	WNL or : _____
TMJ EXAM	WNL or : _____
OCCLUSION	CLASS I II II
ORTHO	☐ YES ☐ NO

In Office Notes

BP:

PULSE:

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

_____

PATIENT / GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

_____

DR.'S SIGNATURE DATE