ULTRA SMILE Dentistry

Chart #: _____

Name _____
Last First Middle

Date of Birth: ____/____/____ Social Security No: _____ Sex: _____ Marital Status: _____

Address: _____

Email: _____ Home Phone: _____

Work Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____

**Insurance:** Yes / No Insurance Company: _____ Subscriber: _____

SS# of Subscriber: _____ Date of Birth: ___/___/___ Relationship to Subscriber: _____

How were you referred to the office? _____

## Medical History

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Are you in good health? | ☐ | ☐ | Respiratory Problems, emphysema, or bronchitis |
| ☐ | ☐ | Have you ever had any serious illness or operations? | ☐ | ☐ | Kidney infection |
| ☐ | ☐ | Damaged or artificial heart valves; rheumatic fever | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Heart or cardiovascular disease | ☐ | ☐ | Sexually transmitted disease |
| ☐ | ☐ | High blood pressure | ☐ | ☐ | Epilepsy or neurological disease |
| ☐ | ☐ | Abnormal bleeding | ☐ | ☐ | Cancer _____ |
| ☐ | ☐ | Stroke | ☐ | ☐ | Radiation treatments for cancer, tumors, or growth |
| ☐ | ☐ | Allergies to medicine or drugs | ☐ | ☐ | AIDS or HIV infection |
| | | If yes, what? _____ | ☐ | ☐ | Allergic to penicillin or codeine |
| ☐ | ☐ | Sinus trouble | ☐ | ☐ | Pregnant or nursing (circle one) |
| ☐ | ☐ | Asthmas or hay fever | ☐ | ☐ | Are you taking birth control pills |
| ☐ | ☐ | Fainting spells or seizures | ☐ | ☐ | Thyroid problems |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Do you have any health concerns not mentioned? |
| ☐ | ☐ | Hepatitis, jaundice or liver disease | | | If yes, what? _____ |

## Dental History

☐ ☐ Do you grind your teeth at night ☐ ☐ Are you currently experiencing pain or discomfort?

Date of your last dental exam? _____ Date of last dental x-rays? _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

List any drugs you are currently taking: _____

Pharmacy: _____ Phone: _____

**IN CASE OF AN EMERGENCY**

Please notify: _____ Phone: _____ Relationship: _____

### Representations

- I understand that the information I have provided (including my medical history) is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status
- I authorize this office to verify my credit status prior to extending credit for treatment, and at the discretion of this office to use the service of one or more credit reporting services
- I authorize payment directly to this office of any insurance benefits otherwise payable to me and I assign any and all benefits to this office. I also understand that I am responsible for all services rendered and I am responsible for any co-payments and deductible the insurance does not cover
- I understand that collection efforts are undertaken due to failure to pay any and all fees to this office
- I consent to and authorize treatment recommended by the dental staff

_____ _____
**Signature (parent if minor)** **Date**

_____ _____
**Doctors Signature** **Date**