PATIENT HISTORY & INFORMATION

Today's Date:

5586 Post Road • East Greenwich, Rhode Island 02818 • Tel: (401) 884.3110 • Fax: (401) 885.7258 • www.SmileDesignersRI.com

PATIENT INFORMATION

PATIENT'S NAME: Last: First: Middle Initial: Sex: M F

AGE: BIRTH DATE: Social Security #.

If Patient is a Minor, please provide Parents/Guardian's Name: Who May Thank for Referring You to Our Office?

Reason for Visit Us Today?

RESPONSIBLE PARTY INFORMATION

PATIENT'S NAME: Last First: Middle Initial: Sex: M F

AGE: BIRTH DATE: Social Security #. MARITAL STATUS

STREET ADDRESS:

CITY STATE ZIP How long have you lived here?

WORK PHONE: HOME PHONE: CELL PHONE:

EMPLOYER: OCCUPATION: # OF YEARS EMPLOYED:

RESPONSIBLE PARTY'S

LAST NAME: FIRST NAME: MIDDLE:

EMPLOYER: OCCUPATION: YEARS:

SS# BIRTH DATE:

HOME PHONE: CELL/EVENING PHONE:

EMAIL:

EMERGENCY INFORMATION:

LAST NAME: FIRST NAME: MIDDLE:

ADDRESS:

RELATIONSHIP TO PATIENT: BIRTH DATE:

HOME PHONE: CELL/EVENING PHONE:

EMAIL:

PRIMARY DENTAL INSURANCE INFORMATION:

INSURED'S NAME:

RELATIONSHIP TO PATIENT:

INSURANCE COMPANY:

RELATIONSHIP TO PATIENT: BIRTH DATE:

HOME PHONE: CELL/EVENING PHONE:

EMAIL:

SECONDARY DENTAL INSURANCE COVERAGE:

INSURED'S NAME:

RELATIONSHIP TO PATIENT:

INSURANCE COMPANY:

RELATIONSHIP TO PATIENT: BIRTH DATE:

HOME PHONE: CELL/EVENING PHONE:

EMAIL:

It is important that we know your Medical and Dental History. This information is strictly confidential and will not be released to anyone. Please check YES or NO to the items below. Thank you.

DENTAL HISTORY	YES	NO
How Long since you last saw a dentist?	☐	☐
How Long since your last complete Dental Exam?	☐	☐
How Long since your last full-mouth X-RAYS?	☐	☐
Are you having PROBLEMS now?	☐	☐
What PROBLEMS are you experiencing?	☐	☐
Is Your present dental health POOR?	☐	☐
Do You Wear DENTURES?	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Have you had any Periodontal (GUM) Treatments?	☐	☐
Do your gums BLEED or feel IRRITATED or TENDER?	☐	☐
Are your teeth SENSITIVE to heat, cold, sweets? (circle)	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you ever worn BRACES (Orthodontics)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like to IMPROVE or CHANGE your smile?	☐	☐
Do you regularly use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

MEDICAL HISTORY	YES	NO	
Do you have any CURRENT MEDICAL PROBLEMS?	☐	☐	What?
Are you under a PHYSICIAN'S CARE now?	☐	☐	For WHAT?
Are you taking any MEDICATIONS?	☐	☐	What medications?
Have you ever taken Fen-Phen/Redux?	☐	☐	
Are you PREGNANT?	☐	☐	
Do you SMOKE cigars, cigarettes or chew tobacco? (circle)	☐	☐	

Please CHECK YES OR NO TO THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO
AIDS/HIV Positive.	☐	☐	Psychiatric Care	☐	☐
Heart Disease/Attack/Murmur?	☐	☐	Stroke, hardening of arteries?	☐	☐
Asthma, Emphysema, other Lung Diseases?	☐	☐	Hepatitis, other Liver Disease?	☐	☐
Stomach Problems, Ulcers?	☐	☐	Thyroid, Adrenal Disease?	☐	☐
Radiation Treatments?	☐	☐	Prosthetic Heart Valve?	☐	☐
Seizure Disorder?	☐	☐	Sleep Apnea or use CPAP Machine?	☐	☐
Tumors, Cancer?	☐	☐	Rheumatism?	☐	☐
Glaucoma?	☐	☐	Tuberculosis?	☐	☐
Kidney, Bladder Disease?	☐	☐	Diabetes?	☐	☐
Artificial Joint?	☐	☐	Pacemaker?	☐	☐
Drug Abuse?	☐	☐	Fainting?	☐	☐

Is there any other Medical or Dental Information that you feel we should know about?

Family Physician: Phone: Email:

Patient Signature (Parent of Child) **Date:** **Dentist Signature:**