(PLEASE PRINT)

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient's Last Name: First: Middle: | | | Preferred name: |
| Sex: ❑ M ❑F | Marital status (circle one): Single Married Child | Date of birth: / / | Social Security #: |
| Street address: | | | Apt. #: |
| City: | State: | | Zip Code: |
| E-mail: (To be used for reminders, appointment confirmations and billing) | | | |
| Home phone: ( ) | Work phone: ( ) | | Cell phone: ( ) |
| How did you hear about us? (please check one box): ❑ Dr. referral Name: ❑ Family ❑ Friend ❑ Insurance Plan ❑ AT&T yellow pages ❑ Internet Search ❑ Other_____ | | | |
| Employer: | | | Position: |
| Employer address: | | | |
| Spouse's name: | | | Spouse's cell #: ( ) |
| Preferred billing method: ❑ Text ❑ Email (By checking either box, you are consenting to receive billings statements via the selected method) | | | |

## PRIMARY INSURANCE INFORMATION

| | | |
|---|---|---|
| Primary policy holder's name: | Address (if different): | |
| Primary policy holder's social security #: | Policy holder's date of birth: / / | Policy holder's employer: |
| Relation to patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other | Insurance company: | Group #: |

## SECONDARY INSURANCE INFORMATION

| | | |
|---|---|---|
| Secondary policy holder's name: | Address (if different): | |
| Secondary policy holder's social security #: | Policy holder's date of birth: / / | Policy holder's employer: |
| Relation to patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other | Insurance company: | Group #: |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone: ( ) | Work phone: ( ) |

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carolina Smiles or my insurance company to release any information required to process my claims.**

**Acknowledgement of receipt of Notice Of Privacy Practices. I have received a copy of this office's Notice of Privacy Practices.**

*Patient/Guardian Signature* _____ *Date*_____

**PLEASE MARK "YES" OR "NO" FOR EACH BOX**

| Dental History | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Bad breath | | | Fingernail biting | | | Mouth pain, brushing | | |
| Bleeding gums | | | Food collection between the teeth | | | Orthodontic treatment | | |
| Blisters on lips or mouth | | | Foreign objects | | | Pain around ear | | |
| Burning sensation on tongue | | | Grinding teeth | | | Periodontal treatment | | |
| Chew on one side of mouth | | | Gums swollen or tender | | | Sensitivity to cold | | |
| Cigarette, pipe, or cigar smoking | | | Jaw pain or tiredness | | | Sensitivity to heat | | |
| Smokeless tobacco use | | | Lip or cheek biting | | | Sensitivity to sweets | | |
| Clicking or popping jaw | | | Loose teeth or broken fillings | | | Sensitivity when brushing | | |
| | | | Mouth breathing | | | Sores or growths in your mouth | | |
| | | | | | | Dry mouth | | |

| Medical History | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Aids/HIV | | | Emphysema | | | Radiation Treatment | | |
| Anemia | | | Epilepsy | | | Respiratory Disease | | |
| Arthritis/Rheumatism | | | Fainting or dizziness | | | Rheumatic Fever | | |
| Artificial Heart Valves | | | Glaucoma | | | Scarlet Fever | | |
| Artificial Joints | | | Headaches | | | Shortness of Breath | | |
| Asthma | | | Heart Murmur | | | Sinus Trouble | | |
| Back Problems | | | Heart Problems | | | Skin Rash | | |
| Bleeding abnormally, with extractions or surgery | | | Hepatitis Type_____ | | | Special Diet | | |
| | | | Herpes | | | Stroke | | |
| | | | High Blood Pressure | | | Swollen Feet or Ankles | | |
| Blood Disease | | | Jaundice | | | Swollen Neck Glands | | |
| Cancer | | | Jaw Pain | | | Thyroid Problems | | |
| Chemical Dependency | | | Kidney Disease | | | Tonsillitis | | |
| Chemotherapy | | | Liver Disease | | | Tuberculosis | | |
| Circulatory Problems | | | Low Blood Pressure | | | Tumor or growth on head or neck | | |
| Congenital Heart Lesions | | | Mitral Valve Prolapse | | | | | |
| Cortisone Treatments | | | Nervous Problems | | | Ulcer | | |
| Cough, persistent or bloody | | | Pacemaker | | | Venereal Disease | | |
| | | | Pregnant (currently) | | | Weight Loss, unexplained | | |
| Diabetes | | | Psychiatric Care | | | | | |

| Medications | Allergies | Yes | No |
|---|---|---|---|
| List any medications you are currently taking and the correlating diagnosis | Aspirin | | |
| | Barbiturates (Sleeping pills) | | |
| | Codeine | | |
| | Iodine (Seafood Allergy) | | |
| | Latex | | |
| | Local Anesthetic | | |
| | Penicillin | | |
| | Sulfa | | |