(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 tha financially responsible for any balance. I also authorize Carolina Smiles or my insurance company to release any information required to process

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						Pain around ear		
			Foreign objects			Periodontal treatment		
Burning sensation on tongue			Grinding teeth			Sensitivity to cold		
			Gums swollen or tender			Sensitivity to heat		
Chew on one side of mouth						Sensitivity to sweets		
			Jaw pain or tiredness			Sensitivity when brushing		
Cigarette, pipe, or cigar smoking			Lip or cheek biting					
			Loose teeth or broken fillings			Sores or growths in your mouth		
Smokeless tobacco use								
Clicking or popping jaw			Mouth breathing			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		