CAREFREE SMILE

COSMETIC & RESTORATIVE
DENTISTRY

Name: _____
Last First Initial Preferred Title/Suffix

Sex: M F DOB: _____ Marital Status: _____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Carefree PO Box:_____

Email Address:_____

Cell Phone:_____ Please indicate with a star which phone is preferred.

Home Phone:_____ Work Phone:_____

Emergency Contact Name: _____ Phone: _____

Names of any family members that are patients of record: _____

Whom may we thank for referring you? _____

Please tell us how we can make your time here more comfortable and enjoyable:

_____

_____

What is the primary reason for your visit today? Are there specific concerns you would like addressed?

_____

What is your dental philosophy? Do you prefer to be reactive or proactive with dental care?

_____

For Patients With Dental Insurance:

Insurance Information:_____

SSN: _____ Insurance ID: _____

Employer: _____ Employer Phone:_____

Employer Address: _____

DENTAL HISTORY

When did you last see a dentist? _____

What has been your typical dental cleaning schedule? _____

Have you ever been treated for periodontal disease? _____

Why did you leave your previous dentist? _____

Does visiting a dentist make you feel nervous or anxious? _____

MEDICAL HISTORY

___Heart Problems	___Epilepsy	___TMJ Disorder
___High Blood Pressure	___Headaches	___Rheumatic Fever
___Low Blood Pressure	___Hepatitis, Liver Disease	___Sinus Problems
___Circulatory Problems	___Cancer	___Stroke
___Nervous Problems	___Psychiatric Care	___Diabetes
___Radiation Treatment	___Ulcer	___Venereal Disease
___Hemophilia	___Allergies to Anesthetics	___HIV/AIDS
___Recent Weight Loss	___Allergies to Medications	___Blood Disease
___Back Problems	___General Allergies	___Arthritis
___Respiratory Disease	___Immunosuppressive Disorder	___Chemical Dependency
___ Artificial Heart Valve	___ Infective Endocarditis	___Currently Pregnant

Known drug allergies: _____

Current medications: _____

Have you been told by a physician or dentist to pre-medicate with antibiotics prior to a dental cleaning?

_____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____

Is there anything else we should know about your medical or dental history?

_____

_____

This information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist and/or any staff member responsible for any errors or omissions that may have been made in completion of this form. I consent to all necessary dental diagnostic procedures, including, but not limited to; x rays, examinations, photographs and diagnostic tests. I consent to allow my dental photographs to be used for diagnostic and educational purposes.

I understand that my insurance is billed as a courtesy and that I am responsible for all fees incurred. Should my account be sent to collections, I understand am responsible for any collection fees.

Signature_____ Date_____