Smile Smart Dental Center
7270 East 55th Avenue
Bradenton, FL 34203

Phone 941.755.8480
smilesmartdentalcenter.com

Welcome to Smile Smart!

Please tell us about yourself:

Name (Last, First, MI) ______________________________

Preferred Name ______________________________ Circle: Male Female

Address ______________________________

City ______________________________ State ______________ ZIP ______________

SSN ______________________________ DOB ______________________________

Home Phone ______________________________ Work Phone ______________________________

Cell Phone ______________________________ E-mail Address ______________________________

Employer ______________________________ Occupation ______________________________

Marital Status (circle): Single Married Divorced Widowed Separated Domestic Partner

How did you hear about our office? ______________________________

Do you prefer to be contacted for appointment confirmation via e-mail or phone? ______________________________

Insurance

Subscriber Name ______________________________

Relationship to Patient ______________________________ Subscriber DOB ______________________________

Subscriber SSN/ID ______________________________ Subscriber Employer ______________________________

Insurance Company Name ______________________________

Insurance Company Address ______________________________

Insurance Company Phone ______________________________ Group Number ______________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Smile Smart all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______________________________

Relationship ______________________________ Date ______________________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature ______________________________

Please complete other side

Medical History

Do you have a personal physician? (circle one) Yes No

Physician's Name ______________________________

Physician's Phone ______________________________ Date of last visit ______________________________

What is your current physical health? (circle one) Good Fair Poor

Are you currently under the care of a physician? (circle one) Yes No

Please explain ______________________________

Do you use tobacco in any form? (circle one) Yes No

Have you had any metal rods, pins or implants placed? (circle one) Yes No

Are you taking any medications? (circle one) Yes No

Please list each one ______________________________

____

Have you ever had any surgical procedures? (circle one) Yes No

Please list each one ______________________________

Nearest relative not living with you:

Name ______________________________ Relationship ______________________________

Address ______________________________ Phone ______________________________

Conditions

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Allergies
Y N Anemia
Y N Angina Pectoris
Y N Arthritis
Y N Artificial Heart Valve
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Facial Surgery
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N HIV+ AIDS
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N High Blood Pressure
Y N Joint Replacement
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pace Maker
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers

Allergies

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline

If Female

Y N Are you taking Birth Control Pills?
Y N Are you pregnant?

If yes, how long? ____________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature ______________________________ Date ______________________________