# DENTAL INFORMATION

Date of Last Dental Visit______________________ Date of Last Dental Cleaning______________________ Date of Last Full Set of Xrays_________________________

Oral Hygiene Habits: Brush______ x/day Floss________ x/week Mouthrinse _______ x/week, Type_______________________________

1. ***Chief Complaint*:**
   a. What is the main reason for your visit today?_____________________________________________
   b. Are you in pain?_____________________________________________

2. ***Past Dental History***: Have you ever had any of the following?
   a. Orthodontic treatment Y N
   b. Oral Surgery Y N
   Complications_____________________________________________
   c. Periodontal treatment Y N
   d. Bite Adjusted Y N
   e. Worn a nightguard or other intraoral appliance Y N
   f. Loose teeth Y N
   g. Painful or swollen gums Y N
   h. Bleeding gums Y N

3. ***TMJ or Functional Problems***: Do you have any of the following?
   a. Regular headaches Y N
   b. Jaw clicking Y N
   c. Jaw Joint or ear pain Y N
   d. Jaw muscle pain Y N
   e. Neck or shoulder pain Y N
   f. Difficulty opening or closing Y N
   g. Difficulty chewing Y N
   h. Previous history of any of the above Y N

4. ***Habits***: Do you do any of the following?
   a. Clench or grind your teeth Y N
   c. Hold foreign objects with your teeth or chew your fingernails Y N
   d. Mouth breath while asleep or awake Y N
   e. Snore Y N
   f. Feel rested after a good night's sleep Y N
   g. Snack regularly between meals Y N
   h. Drink soda or other sweetened drinks (Gatorade, juices, etc) between meals Y N

5. ***Esthetics***
   a. Do you want to keep your teeth? Y N
   b. Are you happy with the appearance of your teeth? Y N
   c. Would you like to change the color, shape, size or general appearance of your teeth? Y N

6. ***Dental Treatment***
   a. Do you have difficulty with gagging? Y N
   b. Have you ever had an upsetting experience in a dental office? Y N
   c. Is there anything about dental treatment that bothers you?_______________________________ Y N

7. **Children Patients**: Does your child do any of the following?
   a. Sucking thumb, fingers, lips or cheeks Y N
   b. Nursing, bottle or pacifier habits Y N
   c. Frequent ear infections Y N
   d. Do you help your child brush and floss? Y N
   e. Special Concerns_______________________________________
   _____________________________________________________

# FINANCIALLY RESPONSIBLE PARTY INFORMATION *(if different from patient)*

Name: ____________________________________________________________ Social Security #: ______________________________
Last First MI

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other_____________ Birth Date:________________ Email Address:______________________________

Phone (Home): ________________________ (Work): ________________________ Cell:_______________________ Best time to call: ____________________

Address: ____________________________________________________________________________________________
Street Apartment #

____________________________________________________________________________________________
City State Zip Code

Employer______________________________________________________________Occupation_______________________________________

Employer Address__________________________________________________________________________________________

# DENTAL INSURANCE INFORMATION

**Primary Insurance**

Employee Name_____________________________________________

SSN:______________________________Birth Date:________________

Insurance Company_____________________________________________

Address_____________________________________________

Group #______________________ Phone #________________________

**Secondary Insurance**

Employee Name_____________________________________________

SSN:______________________________Birth Date:________________

Insurance Company_____________________________________________

Address_____________________________________________

Group #______________________ Phone #________________________

**Consent for Services**

-As a condition of your treatment, financial arrangements must be made in advance. Any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed.
-Insurance payments will be assigned directly to Dr. Steven E. Smith, DDS unless other financial arrangements have been made.
-Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental charges. We will be glad to process your insurance forms at no charge
-A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I have read the above conditions of treatment and payment and agree to their content.

_______________________________________________________ Date: _____________ Relationship to Patient:________________________________
Signature of patient, parent or guardian

_______________________________________________________ Date: _____________ Relationship to Patient:________________________________
Signature of guarantor of payment/responsible party