PATIENT INFORMATION

Welcome to our office!

To assist us in serving you, please complete the following information.
The information provided is important to your dental health.

Patient's Name _____ Birth Date _____

Preferred Name _____ Gender _____ Phone # _____

Mailing address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's Name _____ ❑ Unmarried

How did you find us? _____

Billing and Insurance Information: ❑ I'm not covered by Dental Insurance

Dental Insurance Co. _____

SSN _____ Group Number _____

Covered by Spouse's Insurance? ☐Yes ☐No Spouse Birth Date _____

Spouse Dental Insurance CO. _____

Spouse SSN _____ Group Number _____

DENTAL HEALTH HISTORY

Do your gums bleed when you brush or floss? ☐ Yes. ☐ No ☐ Don't Know

Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes. ☐ No ☐ Don't Know

Does food or floss catch between your teeth? ☐ Yes. ☐ No ☐ Don't Know

Is your mouth dry a lot if the time? ☐ Yes. ☐ No ☐ Don't Know

Have you had any periodontal (gum) treatments ☐ Yes. ☐ No ☐ Don't Know

Have you ever had orthodontic (braces) treatment? ☐ Yes. ☐ No ☐ Don't Know

Have you ever had a bad dental office experience in the pasted? ☐ Yes. ☐ No

How do you feel about your smile? _____

Date of your last dental exam: _____ What was done at your last dental appointment?

_____

Date of last dental X-rays: _____ How many X-rays where taken at that time: ☐ 1 ☐ 4 ☐ 6+ ☐ Don't Know

Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No

If Yes, pleas describe: _____

What is the reason for your dental Hygiene visit today? _____

PATIENT INFORMATION

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check all that apply)

- ☐ Cancer or Tumor
- ☐ Heart Ailment or Angina
- ☐ Heart Murmur, Mitral Valve Prolapses, Heart Defect
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Artificial joint or Heart Valve
- ☐ High or Low Blood Pressure
- ☐ Pacemaker
- ☐ Tuberculosis or Other Lung Problems
- ☐ Kidney Disease
- ☐ Hepatitis _____ or Other Liver Disease
- ☐ Alcoholism
- ☐ Blood Transfusion
- ☐ Diabetes
- ☐ Neurologic Condition
- ☐ Epilepsy, Seizures, or Fainting Spells
- ☐ Emotional Condition
- ☐ Arthritis
- ☐ Herpes or Cold Sores
- ☐ AIDS or HIV Positive
- ☐ Migraine Headaches or Frequent Headaches
- ☐ Anemia or Blood Disorders
- ☐ Abnormal Bleeding after Extractions, Surgery, or Trauma
- ☐ Hay Fever or Sinus Trouble
- ☐ Allergies or Hives
- ☐ Asthma

Do you have any other disease/s, condition/s, or medical problem/s not listed above?

_____

_____

Rx Medications and Over the Counter Medications, Drugs, Vitamins, or Supplements:

_____

_____

_____

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics ("Novocain")
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other _____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

Do you us marijuana? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No

Women:

Could be Pregnant? ☐ Yes ☐ No ☐ Maybe

Due Date _____

- ☐ Are you currently Nursing
- ☐ Taking Contraceptives or Hormones
- ☐ Menopause: ☐ Yes ☐ No ☐ Maybe

Name of you Physician/office _____

Date of last visit _____ Physician Phone Number _____

PATIENT INFORMATION

CONSENT FOR SERVICE

- ☐ I understand that am being seen by a licensed Colorado Dental Hygienist.
- ☐ I understand that it is recommended and that it is my responsibility to see a licensed Dentist for a dental exam twice a year.
- ☐ I understand that Smile Rockers may discuss our patients records with a local dentist.
- ☐ I understand that Smile Rockers will send my X-rays and request that they be read by a licensed dentist.
- ☐ I understand that emails and X-rays sent to other health care professionals will not be encrypted. (appointment reminders, treatment notes, etc.)
- ☐ I know that Social Security Numbers and insurance information is only shared with insurance companies and that this information will be encrypted.
- ☐ Payment for services rendered is the sole responsibility of the patient or responsible party. Smile Rockers will gladly bill insurance as a service for you, but any nonpayment or partial payment is then the patient's responsibility. Nonpayment may result in turning over your account over to a collection agency.

To the best of my knowledge, all the answers and the information provided are true and correct.

Print: Patient Name _____ Guardian Name _____

Signature: of Patient (or Guardian) _____ Date: _____