Welcome to Legendary Smiles

We look forward to working with you in maintaining your dental health

PATIENT INFORMATION Today's Date___________________

Name____ I prefer to be called______________________________
Age________ Birth Date____/____/____ Male/Female Soc Sec#_____-_____-________
Address_______________________________________City__________________State_________Zip_________
Home Phone _________________ Work Phone_____________________ Cell Phone________________________
Email Address: ____
Child___ Single___ Married___ Widowed___ Separated ___ Divorced___
Patient Employed by___________________________________Occupation_________________________________
If a Child, name of Father________________________________Phone__________________________
Address________________________________City________________________State_________________
Name of Mother _______________________________Phone_____________________
Address________________________________City________________________State_________________

Notify in case of emergency_______________________Relation_____________Phone___________________
Person Responsible for Account ________________________________ Relation to Patient_________________
DOB___/___/___ Soc. Sec. #_______-_____-________ Phone____________________________
(If different from patient) Address____________________________City_________State______Zip___________
ARE YOU COVERED BY MEDICAL ASSISTANCE/MEDICAID? Yes or No. If Yes #_______________________

PRIMARY DENTAL INSURANCE

Insurance Company ____________________________Insurance Address__________________________________
Ins Phone#_____________________________ Subscriber Name _____________________ DOB________________
Subscriber's Place of Employment____________________ Subscriber #_________________Group#___________
Do you have additional dental insurance? Yes or No. Name:____
DENTAL HISTORY
What would you like us to do today? _________________________________ Are you in dental discomfort? Y/N
Former Dentist___________________________Address_______________________Phone___________________
Date of last dental care ________________________________Date of last X-rays___________________________
Make a check mark if you have had problems with any of the following:
___Bad Breath ___Food collection between teeth ___Periodontal treatment ___Sensitivity to sweets
___Bleeding gums ___Grinding or clenching teeth ___Sensitivity to cold ___Sensitivity when biting
___Clicking/Popping jaw ___Loose teeth or broken fillings ___ sensitivity to hot ___Sores/growths in mouth
How often do you brush?____ How often do you floss?____ How do you feel about the appearance of your teeth?_____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes/no
Explain____
MEDICAL HISTORY
Physician's name______________________________Address_______________________Phone______________
Date of last visit______________ Have you ever had a blood transfusion? Yes/No If yes, date________________
Have you had any serious illness or operations? Yes/No If yes, describe_________________________________
WOMEN: Are you Pregnant? Yes/No if yes, Due Date:_______ Nursing? Yes/No Taking birth control? Yes/No

********PLEASE FILL OUT THE BACK SIDE********

MAKE A CHECK MARK IF YOU HAVE HAD ANY OF THE FOLLOWING:

___Abnormal Bleeding	___Chemotherapy	___Herpes	___Rheumatic fever
___AIDS	___Circulatory Problems	___Hepatitis	___Scarlet fever
__Anaphlaxsis	___Colitis	___HIV positive	___Seizure
___Anemia	___Cortisone treatment	___Jaw Pain	___Shingles
___Anorexia	___Cough, persistent	___Kidney Problems	___Shortness of breath
___Arthritis, Rheumatism	___Diabetes	___Liver Disease	___Sinus Problems
___Artificial joints	___Epilepsy	___Material allergies	___Multiple Sclerosis
___Asthma	___Fainting	___Mitral Valve Prolapse	___Spina Bifida
___Atopic (allergy prone)	___Fever blisters	___Nervous problems	___Stoke
___Back problems	___Food allergies	___Pacemaker	___Surgical implant
___Blood Disease	___Glaucoma	___Fen-Phen use	___Swelling feet/ankles
___Blood pressure problems	___Headaches	___Radiation treatment	___Thyroid Problems
___Cancer	___Heart Murmur	___Rapid weight gain/loss	___Tuberculosis
___Chemical dependency	___Heart problems	___Respiratory disease	___Venereal disease
___Bisphosphonate Therapy			

SPECIFIC HEART PROBLEMS: ____
Any other conditions not listed: ____

Allergies? Yes/no
Penicillin___Aspirin___Erythromycin___Tetracycline___Latex___Codine___Morphine__Cephelexin__Dental Anesthetics__
Other allergies NOT listed:____

List medications you are currently taking, if any: ____
____

Has your medical doctor ever recommended you take an antibiotic premed prior to any dental work? **Yes/No**
Explain:____

AUTHORIZATION

I have reviewed the information on both sides of this questionnaire and the information is accurate to the best of my knowledge. I understand Legendary Smiles will file insurance as a courtesy, however all charges on my account are my responsibility. The balance on my account is due in full at the time of treatment. We accept cash, check or credit cards. We will discuss a payment plan with you. Interest at the rate of 1.5% will accrue monthly on charges carried over 90 days. If default in payment occurs, the entire balance becomes due immediately. I will be responsible for any collection fees charged to my account.

Signature____Date_______________________

Acknowledgment of Receipt of Notice of Privacy Practice

I,______________________________, have acknowledgement of this office's Notice of Privacy Practices.

Print Patient Name________________________________Date________________________

Signature____ (if child, Relation to Patient_______________)

We use **Nitrous Oxide Sedation** in our dental office to help with anxiety. If you want to use the option of Nitrous Oxide sedation, **please read the following about nitrous oxide and then sign and date below**. Nitrous oxide leads to impaired motor control, with such symptoms as tingling in your fingers, lips, tongue, hands, and chest, feeling of warmness, dizziness, heaviness, and a feeling of being far away. People who should not use it: Pregnant women, someone with upper respiratory tract infection, chronic obstructive pulmonary disease, recovering addict, someone with psychological problems, and middle ear infection. People who breathe nitrous oxide may experience nausea, especially if they have just eaten. We recommend not eating 6 hours prior to using the nitrous oxide.

Signature____ Date__________________________