Patient Information:

Name of patient _____ Nickname_____

Sex: _____ Patient's Physician: _____

Date of Birth: _____ Date Of Last Exam: _____

Names of both parents: _____

Father's Occupation (optional): _____

Mother's Occupation (optional): _____

Address: _____

City:_____ State:_____ Zip code:_____

Home phone: _____ Cell phone: _____

Email: _____

If patient has had any of the following, please circle:

1. Allergies to medicines
2. Other allergies
3. Heart problems
4. Rheumatic fever
5. Heart murmur
6. High or low blood pressure
7. Neurological problems (such as seizures)
8. Endocrine problems (such as diabetes)
9. Cancer
10. Respiratory (breathing) problems
11. Kidney or urinary tract problems
12. Liver problems (such as hepatitis)
13. Significant stomach or digestive system problems
14. Bleeding disorders
15. Anemia
16. Blood transfusion
17. Skin problems
18. Eye, ear, nose or throat problems
19. Recurrent headaches
20. Jaw joint (TMJ) problems
21. Rheumatoid arthritis
22. Immune system problems (such as AIDS)
23. Sexually transmitted diseases

If yes, please explain: _____

- Does the patient have any physical disabilities that are congenital (such as cleft lip or cerebral palsy) or acquired (such as those from trauma or infection)? _____

- Has growth and development been on schedule?

  Physically? _____ Psychologically? _____ Socially?_____

- Does the patient have any problems with:

  Speech? _____ Hearing? _____ Vision? _____

- Are tonsils and adenoids present? _____

- Has the patient ever been hospitalized? _____ If yes, for what? _____.

- Has the patient received injuries to the teeth, mouth, face or head? _____

- Does the patient have any other conditions or problems of a significant nature? _____

- Is the patient taking any medicine, now? _____

- Is the patient taking any medicine on a regular basis? _____

- To help us see growth patterns:

  - Have other family members had orthodontic treatment (like braces)? _____

  - Is the patient adopted? _____ Does the patient know? _____

- Is the patient taking fluoride by prescription (such as tablets or drops)? _____

- Does the patient consume water supplied by your city or town? _____

- Does the patient have any oral habits (such as thumb sucking or pacifier use)?

  _____

- Did the patient ever sleep with a bottle? _____

- Has the patient been to a dentist before? _____ A pediatric dentist? _____
- Were dental x-ray films made? _____ Approximately when? _____
- Was the experience generally favorable? _____
- Is the patient having any particular problems, now? _____

  _____
- Are there any particular questions you would like Dr. Smith to address? ____

  _____
- Please list any favorite hobbies or activities_____
- Whom may we thank for referring you to us? _____

Signed: _____

Relationship to patient: _____

Date: _____

Subscriber's Dental Insurance Information:

Name of Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Name of Insurance Carrier: _____

Insurance Carrier Address: _____

City: _____ State:_____ Zip Code:_____

Subscriber's ID Number: _____

Insurance Group Number: _____

Employer's Name: _____

Please continue to page 5

Herbert S. Smith, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____ have received a copy of this office's Notice of Private Practices.

_____

Please Print Name

Signature : _____ Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our office Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barriers prohibited obtaining the acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other (Please Specify)

_____

_____

_____