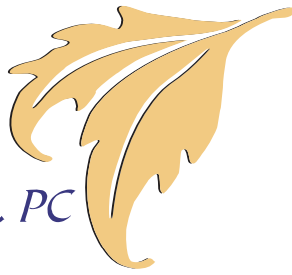


# SOPHISTICATED SMILES



*The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you*

by

*Angela R. Cameron, DDS. PC*

SS # \_\_\_\_\_

Today's Date \_\_\_\_\_

Email Address \_\_\_\_\_

## Patient Information

Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's or Parent's Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

If Patient is a Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

How did You Hear about our Practice? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Responsible Party

Name of Person \_\_\_\_\_ Relation \_\_\_\_\_  
Responsible for this Account \_\_\_\_\_ to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Currently a Patient in our Office?  Yes  No

## Insurance Information

Name of Insured \_\_\_\_\_ Relation \_\_\_\_\_  
to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much is Your Deductable \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

## Additional Insurance

Name of Insured \_\_\_\_\_ Relation \_\_\_\_\_  
to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much is Your Deductable \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

# DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Address \_\_\_\_\_ Are You Happy with Your Smile? \_\_\_\_\_

(x) If you have had any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat           |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets         |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting       |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growth in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

# MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Is Your Current Physical Health?  Good  Fair  Poor

Have you ever taken any of the group of drugs collectively referred to as "fen-phen" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Do you Smoke or use Tobacco of any Form?  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

List medications you are currently taking and the correlating diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

# AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. After 45 days from the date of service, all balances must be paid regardless of insurance payment. In the event that collection procedures are necessary, the patient will be responsible for collection and court cost.

I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor

Date

***Payment is due in full at time of treatment unless prior arrangements have been approved.***