Patient Information *(Información del Paciente):*

Legal Last Name *(Apellido(s) completos)*____

Legal First Name (*Nombre completo*) ____MI___________________

Preferred Name (*Nombre preferido*)____

Permanent Address (*Dirección permanente)*____ Apt #:________________

City *(Ciudad)*_________________________________ State (*Estado*)_________ Zip Code *(Código Postal)*______________________

Date of Birth *(Fecha de Nacimiento)* ______/______/______ Social Security *(Seguro Social)*___________________________________

Male ☐ Female ☐ Transgender☐ *(Sexo: Femenino ☐ Masculino ☐ Transgénero ☐)* Marital Status (*Estado Civil*)_____________________

Home # *(Teléfono)*____________________________________Work # (*Trabajo*) ____________________________________

Cell # *(Celular)*_______________________________________ Email (*Correo electrónico*)____________________________

I prefer to be contacted by: (*¿Como prefiere que nos comuniquemos con usted?)*
Mark all that apply:
Telephone (*Teléfono)* ☐ Cell Phone *(Celular)* ☐ Text *(Texto)* ☐ Email (*Correo electrónico*) ☐

Responsible Party Information (*Información de la Persona Responsable):*

If same as above, check box *(Si es la misma información de la parte superior, marque la casilla):* ☐

Legal Last Name *(Apellido(s) completos)*____

Legal First Name (*Nombre completo*) ____MI___________________

Preferred Name (*Nombre preferido*)____

Permanent Address (*Dirección permanente)*____ Apt #:________________

City *(Ciudad)*_________________________________ State (*Estado*)_________ Zip Code *(Código Postal)*______________________

Date of Birth *(Fecha de Nacimiento)* ______/______/______ Social Security *(Seguro Social)*___________________________________

Home # *(Teléfono)*____________________________________Work # (*Trabajo*) ____________________________________

Cell # *(Celular)*_______________________________________ Email (*Correo electrónico*)____________________________

Relationship to Patient *(Relación con el paciente)*____

Emergency Contact (*Información del Contacto de Emergencia):*

Legal Last Name *(Apellido(s) completos)*____

Legal First Name (*Nombre completo*) ____MI___________________

Permanent Address (*Dirección permanente)*____ Apt #:________________

City *(Ciudad)*_________________________________ State (*Estado*)_________ Zip Code *(Código Postal)*______________________

Telephone *(Teléfono)* _________________________________Relationship to Patient *(Relación con el paciente)*__________________

Where did you hear about our practice? ___________________________________
Who can we thank for referring you? _____________________________________

Dental Insurance *(**Seguro Dental)*** **YES** or **NO (*SÍ o NO*)**
If your answer is no, please do not fill out the rest of this section *(Si su respuesta es no por favor no llene el resto de esta sección)*

Policy Holder's Name (*Titular de la Poliza*)____

Employer Name & Phone (*Nombre y number de telefono del empleador*)______________________________

Insurance Company's Name *(Nombre de la compañía de seguros)* ____________________________________

Insurance Company Address (*Dirección de la compañía de seguros)*__________________________________

Insurance Company Phone *(Número de teléfono de la compañía de seguros)*____________________________

Date of Birth of Insured Party (*Fecha de nacimiento del asegurado*) ___________/______/_________

Relationship to Patient *(Relación con el paciente)* ____

Group/Policy # (*Numero de Grupo/Poliza)*____

Social Security Number *(Numero de Seguro Social)*____

Secondary Dental Insurance (***Seguro Dental Secundario)*** **YES** or **NO (*SÍ o NO*)**
If your answer is no, please do not fill out the rest of this section *(Si su respuesta es no por favor no llene el resto de esta sección)*

Policy Holder's Name (*Titular de la Poliza*)____

Employer Name & Phone (*Nombre y number de telefono del empleador*)______________________________

Insurance Company's Name *(Nombre de la compañía de seguros)* ____________________________________

Insurance Company Address (*Dirección de la compañía de seguros)*__________________________________

Insurance Company Phone *(Número de teléfono de la compañía de seguros)*____________________________

Date of Birth of Insured Party (*Fecha de nacimiento del asegurado*) ___________/______/_________

Relationship to Patient *(Relación con el paciente)* ____

Group/Policy # (*Numero de Grupo/Poliza)*____

Social Security Number *(Numero de Seguro Social)*____

THANK YOU FOR CHOOSING SMILE ALWAYS!

The information provided in both the Dental/Medical History and the Patient Information Form is accurate & complete to the best of my knowledge. I understand that providing misinformation may be perilous to my health and may prevent my dental team from caring for me optimally. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit. I authorize Singh Smiles PLLC and my dentist to release my information, including any diagnosis, treatment or payment records, to third party payers, and/or other healthcare practitioners. I authorize my insurance company to make payments directly to my dentist and Smile Always PLLC.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. In the event of underpayment or denial by my insurance company, I agree to be responsible for the balance of any services or treatment provided to me. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

Appointment times are reserved especially for you. If you come in late, the Doctor may request that you reschedule the appointment and you may be charged a fee of $75. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.
My signature below indicates that I have read, understand and agree to the terms of this Statement.

____ ______________________

Signature of Patient (Parent/Gaurdian) Date

DENTAL AND MEDICAL HISTORY EVALUATION

Patient Name ____

Date of Birth ____________ Height (inches): ________ Weight (lbs):________

MEDICAL HISTORY

Do you have any of the following diseases or problems (active tuberculosis, persistent cough, cough producing blood, exposed to tuberculosis)? ☐ YES ☐ NO
If yes, specify: ______________________________

____

GENERAL MEDICAL INFORMATION:

Are you now, or have you been in the past year, under the care of a physician? ☐ YES ☐ NO
If so, please provide the name, location and phone number of your physician.

____

____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you had an organ transplant? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you had open heart surgery? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you had an orthopedic total joint _ (e.g. hip, knee, elbow, finger) replacement? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you taken (within past 2 years) or are you now taking steroids (e.g. Cortisone)? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you taken, are you taking or are you scheduled to begin taking oral bisphosphonates (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), or Tiludronate (Skelid))?
☐ YES ☐ NO

Have you taken, are you taking or are you scheduled to begin taking intravenous bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))?
☐ YES ☐ NO

TOBACCO USE:

Do you use or have you used tobacco (smoking, snuff, chew, bidis)? ☐ YES ☐ NO
If yes to either, specify______________________________

ALCOHOL USE:

Do you drink alcoholic beverages? ☐ YES ☐ NO
# of drinks per week: _________

FALL RISK ASSESSMENT:

Have you fallen or almost fell in the past three months? ☐ YES ☐ NO
Do you have a fear of falling? ☐ YES ☐ NO
Do you have difficulty walking or moving around? ☐ YES ☐ NO
Do you use an assistive device such as a cane, walker, wheelchair, crutches or artificial limb? ☐ YES ☐ NO
If yes to any of the above, please specify:

____

____

DRUG USE:

Do you use prescription, street drugs or other substances for recreational purposes (incl. marijuana)? ☐ YES ☐ NO
If yes, specify: ______________________________

FEMALES ONLY:

Are you pregnant? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO
Are you taking birth control pills, fertility drugs, hormonal replacement? ☐ YES ☐ NO
If yes, specify: ______________________________

ALLERGIES:

Do you have any allergies (medications, food, other?) ☐ YES ☐ NO
If yes, specify: ______________________________

MEDICAL CONDITIONS:

Do you have or have you had any of the following diseases, problems, or symptoms?

- Heart/Blood Pressure problem ☐ YES ☐ NO
- Respiratory/Lung problem (including sleep apnea) ☐ YES ☐ NO
- Diabetes/Endocrine disorder ☐ YES ☐ NO
- Kidney/Urinary disorder ☐ YES ☐ NO
- Cancer or Tumors ☐ YES ☐ NO
- Neurologic/Nerve problem ☐ YES ☐ NO
- Psychiatric disease/Mental Health Disorder ☐ YES ☐ NO
- Blood/Hematologic disorder ☐ YES ☐ NO
- Stomach/Intestine/Liver disorder ☐ YES ☐ NO
- Muscle/Bone/Connective Tissue disorder ☐ YES ☐ NO
- Infectious disease ☐ YES ☐ NO
- Head/Eye/Ear/Nose/Throat problem ☐ YES ☐ NO
- Dermatologic/Skin problem ☐ YES ☐ NO
- Eating disorder ☐ YES ☐ NO

Do you have any other problem, disease or condition not listed above? ☐ YES ☐ NO
If yes, specify: ______________________________

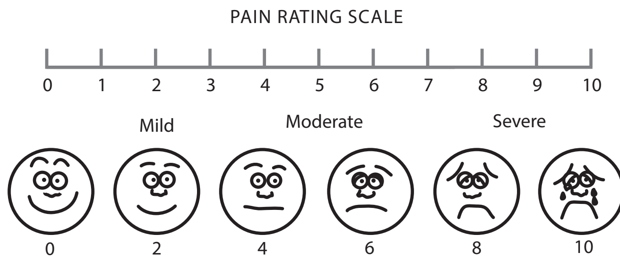
DENTAL HISTORY

What is the reason for your dental visit today? ____
____
____

DENTAL PROBLEMS (SIGNS/SYMPTOMS):

Are you currently experiencing dental pain or discomfort? ☐ YES ☐ NO

If "Yes" to the previous question please mark on the pain schedule how much pain you have.



Have you ever had, or has a dentist ever recommended you have a "deep cleaning?" ☐ YES ☐ NO

Are your teeth sensitive to cold, hot, sweets or pressure? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have problems with eating (trouble chewing, trouble swallowing, vomiting, etc)? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have swelling in or around your mouth, face or neck? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have loose teeth? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have headaches, earaches or neck pains? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have any clicking, popping or discomfort or limited opening in the jaw? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have sores or ulcers in your mouth? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you ever had a serious injury to your head or mouth? ☐ YES ☐ NO
If yes, specify: ______________________________

Are you unhappy with your smile or the appearance of your teeth? ☐ YES ☐ NO

PAST DENTAL TREATMENT:

Have you been to the dentist before? ☐ YES ☐ NO
If so, what is the name, location and phone number of your dentist? ______________________________
____

Do you have a history of significant dental therapy (implants, cosmetic procedures or TMJ surgery)? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you had any periodontal (gum) treatments? ☐ YES ☐ NO
If yes, specify: ______________________________

Do you have bridges or wear dentures or partials? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you ever had root canal treatment? ☐ YES ☐ NO
If yes, specify: ______________________________

Have you ever had orthodontic (braces) treatment? ☐ YES ☐ NO

Have you had a local anesthetic (Novocaine) for dental purposes? ☐ YES ☐ NO

Have you had any problems associated with previous dental treatment? ☐ YES ☐ NO
If yes, specify: ______________________________

DENTAL DISEASE PREVENTION (ORAL HYGIENE/DIET):

How often do you brush your teeth? ____________
How often do you floss your teeth?____________
Do your gums bleed when you brush or floss? ☐ YES ☐ NO

ORAL HABITS:

Do you clench, brux, or grind your teeth? ☐ YES ☐ NO
If yes, specify: ______________________________

MEDICATIONS:

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? ☐ YES ☐ NO

If yes, please list all medications: ______________________________
____
____
____
____