Smile & Implant
Center of Rockland

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Middle Initial*

Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Cell Phone _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Middle Initial*

Relation to Patient _____ Birthdate sadsadsad Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N Bad breath	☐Y ☐N Sensitivity to sweets	☐Y ☐N Sensitivity to cold	☐Y ☐N Loose teeth or broken fillings
☐Y ☐N Food collection between teeth	☐Y ☐N Bleeding gums	☐Y ☐N Sensitivity when biting	☐Y ☐N Sensitivity to hot
☐Y ☐N Periodontal treatment	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Clicking or popping jaw	☐Y ☐N Sores or 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? ☐Y ☐N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____

Date of last visit _____Have you had any serious illnesses or operations? ☐Y ☐N If yes, describe _____

Are you currently under physician care? ☐Y ☐N If yes, describe _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate date(s) _____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cough, persistent	☐Y ☐N High blood pressure	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up blood	☐Y ☐N Jaw pain	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Kidney disease or malfunction	☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Liver disease	☐Y ☐N Spina Bifida
☐Y ☐N Artificial heart valves	☐Y ☐N Fainting	☐Y ☐N Material allergies	☐Y ☐N Stroke
☐Y ☐N Artificial joints	☐Y ☐N Food allergies	(latex, wool, metal, chemicals)	☐Y ☐N Surgical implant
☐Y ☐N Asthma	☐Y ☐N Glaucoma	☐Y ☐N Mitral valve prolapse	☐Y ☐N Swelling of feet or ankles
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Nervous problems	☐Y ☐N Thyroid disease or
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Pacemaker/Heart surgery	malfunction
☐Y ☐N Blood disease	☐Y ☐N Heart problems	☐Y ☐N Psychiatric care	☐Y ☐N Tobacco habit
☐Y ☐N Cancer	Describe _____	☐Y ☐N Rapid weight gain or loss	☐Y ☐N Tonsillitis
☐Y ☐N Chemical dependency	☐Y ☐N Hemophilia/	☐Y ☐N Radiation treatment	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy	Abnormal bleeding	☐Y ☐N Respiratory disease	☐Y ☐N Ulcer/Colitis
☐Y ☐N Circulatory problems	☐Y ☐N Herpes	☐Y ☐N Rheumatic fever	☐Y ☐N Venereal disease
☐Y ☐N Cortisone treatments	☐Y ☐N Hepatitis	☐Y ☐N Scarlet fever	

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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.

I hereby authorize the Smile & Implant Center of Rockland to prescreen my credit worthiness with a third party lender.

Signature _____ Date _____

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