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. #_____

Address_____

City _____ State _____ Zip _____ Email_____

Home Phone_____ Cell Phone _____

☐ "By checking this box, I consent to receive SMS text messages from Smile & Implant Center of Rockland for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out. Please check our privacy policy and terms and conditions for details https://www.smilecenter.org/communication-privacy-policy.php

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_____ Cell Phone_____ Home Phone_____

Work Phone_____ Email _____

Primary Insurance

Person Responsible for Account_____

Relation to Patient_____ Birthdate_____ Soc. Sec #_____

Address (if different from patient)_____ Home Phone_____

City_____ State _____Zip _____

Cell Phone_____ Email_____

Person Responsible Employed by_____ Occupation_____

Business Email_____ Business Phone_____

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)_____ Home Phone_____

City_____ State _____Zip _____

Cell Phone_____ Email_____

Person Responsible Employed by_____ Occupation_____

Business Email_____Business Phone_____

Insurance Company_____ Phone _____

Contract #_____ Group #_____ Subscriber's #_____

Name(s) of other dependents under this plan_____

Dental History

What would you like us to do today?_____

Are you in dental discomfort today?_____

Former Dentist_____ Date of last dental care_____ Date of last X-rays _____

Address_____ Phone_____

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

Medical History

Physician's name_____ Address _____

Physician's email_____ Phone_____

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

For woman only: 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 Anaphylaxis

☐ Y ☐ N Anemia

☐ Y ☐ N Arthritis, Rheumatism

☐ Y ☐ N Artificial heart valves malfunction

☐ Y ☐ N Artificial joints

☐ Y ☐ N Asthma

☐ Y ☐ N Atopic (allergy prone)

☐ Y ☐ N Back problems

☐ Y ☐ N Blood disease

☐ Y ☐ N Cancer

☐ Y ☐ N Chemical dependency

☐ Y ☐ N Chemotherapy

☐ Y ☐ N Circulatory problems

☐ Y ☐ N Cortisone treatments

☐ Y ☐ N Shingles

☐ Y ☐ N Shortness of breath

☐ Y ☐ N Surgical implant

☐ Y ☐ N Cough persistent

☐ Y ☐ N Cough up blood

☐ Y ☐ N Diabetes

☐ Y ☐ N Epilepsy

☐ Y ☐ N Fainting

☐ Y ☐ N Food allergy

☐ Y ☐ N Glaucoma

☐ Y ☐ N Headaches

☐ Y ☐ N Heart murmur

☐ Y ☐ N Heart problems

Describe_____

☐ Y ☐ N Hemophilia/Abnormal bleeding

☐ Y ☐ N Herpes

☐ Y ☐ N Hepatitis

☐ Y ☐ N Swelling of feet or ankles

☐ Y ☐ N Thyroid disease

☐ Y ☐ N Tobacco habit

☐ Y ☐ N High blood pressure

☐ Y ☐ N Jaw pain

☐ Y ☐ N Kidney disease

☐ Y ☐ N Liver disease

☐ Y ☐ N Material allergies

(latex, wool, metal, chemicals)

☐ Y ☐ N Mitral valve prolapse

☐ Y ☐ N Nervous problems

☐ Y ☐ N Pacemaker/Heart surgery

☐ Y ☐ N Psychiatric care

☐ Y ☐ N Rapid weight loss or gain

☐ Y ☐ N Radiation treatment

☐ Y ☐ N Respiratory disease

☐ Y ☐ N Scarlet fever

☐ Y ☐ N Tuberculosis

☐ Y ☐ N Ulcer / Colitis

☐ Y ☐ N Venereal disease

☐ Y ☐ N Stroke

List of 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.