Urban Smiles Dental

WELCOMES YOU

DENTAL HISTORY

Reason for Today's Visit: _____ Date of Last Dental Care: _____

Former Dentist Name: _____ Date of Last Dental X Rays: _____

Check (√) If you have / had problems with any of the following:

☐ **Bleeding Gums**	☐ **Grinding Teeth**	☐ **Sensitivity to hot/ cold**
☐ **Bad Breath**	☐ **Clicking or Popping Jaw**	☐ **Periodontal Treatment**
☐ **Sensitivity while biting**	☐ **Dental Implants**	☐ **Sensitivity to Sweets**
☐ **Food collection between teeth**	☐ **Sores or growths in your mouth**	☐ **Loose teeth or broken fillings**

How often do you floss? _____ How often do you brush? _____

Do you like your smile? ☐ Yes ☐ No If No, please explain: _____

MEDICAL HISTORY

Physician's Name (If under care). _____Date of Last Visit _____

Are you taking or scheduled to take anti-resorptive drugs **(FosamaX, Actonel, Atelvia, Boniva, Reclst, Prolia, Aredia, Zometa, XGEVA**) for bone pain, hyper/ hypo calcemia, Paget's disease, Multiple myeloma or Metastatic cancer ? ☐Yes ☐ No

Have you had any serious illness or hospitalization? ☐Yes ☐ No If yes, describe _____

Have you have had a blood transfusion? ☐Yes ☐ No If yes, give approximate dates _____

(*Women*) Are you pregnant? ☐ Yes ☐ No ☐ Don't know **Nursing**: ☐ Yes ☐ No **Birth Control Pills** ☐Yes ☐ No

Check (√) If you have / had problems with any of the following:

☐ Anemia	☐ Cortisone Treatment	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/ AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemakers	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcers
☐ Circulatory Problems	☐ Excess Bleeding	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List Medication you are currently taking

_____

_____

Pharmacy Name: _____

Phone : (_____)_____

ALLERGIES

☐ **Penicillin**	☐ **Sulfa drugs**
☐ **Barbiturates**	☐ **Later**
☐ **Local Anesthetics**	☐ **Codeine**
☐ **Barbiturates**	

Others: _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Date: _____ Signature: _____

Urban Smiles Dental

Welcomes you

Date: _____ Home Phone: (_____) _____ Cell Phone: (_____) _____

PATIENT INFORMATION

Name _____ , _____ _____ **SS/ Patient ID #** _____
Last Name First Name Middle Initial

Address: _____**E-MAIL**_____

City: _____ **State:** _____ Zip**:** _____

Sex: ☐ M ☐ F **Birth Date:** _____ ☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Other

Patient Employer/ School _____ Occupation**:** _____

Employer/School Address: _____ **Employer/ School Phone**: (_____) _____

Whom may we thank for referring you? _____

In case of Emergency who should be notified? _____ Phone: (_____) _____

PRIMARY INSURANCE

Person Responsible for Account: _____, _____ _____
Last Name First Name Middle Initial

Relation to Patient: _____ **Birth Date**: _____ Soc. **Sec #** _____

Address (If different from patient's) _____ Phone**:** (_____) _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by _____ Occupation**:** _____

Business Address: _____ Business **Phone:** (____) _____

INSURANCE COMPANY _____**GROUP #** _____ **SUBSCRIBER #**_____

Names of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Is patient covered by an additional insurance plan? ☐ Yes ☐ No Relation to Patient: _____

Subscriber Name: _____ **Birth date:** _____ **Soc. Sec #** _____

Address (If different from patient's) _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by _____ Occupation: _____

Business Address: _____ Business Phone: (____) _____

INSURANCE COMPANY _____**GROUP #** _____ **SUBSCRIBER #** _____

Names of other dependents covered under this plan: _____

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have insurance coverage with _____and assigned directly to
Name of the Insurance company (ies)

Urban Smiles Dental P.A all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for their purpose for obtaining payment for services and determining insurance benefits payable for related service

_____ _____
Signature of Patient, Parent, Guardian or Person Representative Date

_____ _____
Please Print Name of Patient, Guardian or Person Representative Relationship to Patient