## Patient Information

Patient Name: _____ _____ _____ _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Birth Date: _____ Age: _____ Email: _____

Phone (Preferred): _____ (other): _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

## Health Information

Date of last physician (medical Doctor) visit: _____ MD Name: _____ PH: _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Allergies (list in section below)
- ☐ Asthma
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Blood Disease
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Thyroid Problem
- ☐ Joint Replacement or Pins/plates in bone

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Emergency Contact: _____ Phone: _____
- Do you have any health problems that need further explanation? ☐ Yes ☐ No
  If yes, please explain: _____

Medications: _____

_____

Allergies (including prescription drugs) _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the hygienist at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

## Referral Information

Whom may we thank for referring you to SmileLogic, Inc.? _____

## Responsible Party Information (if not yourself)

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date:

Phone (Cell): (Work): Ext: Best time to call:

Address:

Street Apartment #

City State Zip Code

Employer Name: Phone:

Address:

## About You

**(We want to get to know you!)**

Occupation (or school if student):

Hobbies/interests:

Something unique about you:

## Dental History

Name of Dentist (current or former) Date of last visit:

Reason for today's visit: Current homecare (circle): Brush Floss WaterPik other

Do you like your smile? Have you ever used or interested in any whitening products?

Please circle:

Do your gums bleed while brushing or flossing? Yes No

Do you have any lumps or sores in or near your mouth? Yes No

Are your teeth sensitive to hot/cold? Yes No

Do you grind or clench your teeth? Yes No

Do you have frequent headaches? Yes No

Do you have dentures or partial dentures? Yes No

Do you feel pain in your mouth or teeth? Yes No

Do you have jaw pain? Yes No

Are your teeth sensitive to sweet? Yes No

Do you wear a night guard or retainer? Yes No

Do you have any dental implants? Yes No

Are you worried that you have bad breath? Yes No

## Consent for Services

____ I understand that I am being seen by a licensed Colorado Dental Hygienist. I understand that is recommended that I see a licensed Colorado Dentist for dental exams yearly and that I am responsible for obtaining those exams.

____I understand that Smile Logic will have my radiographs viewed and evaluated by a licensed dentist.

____I understand that communication will be done via email and that it may not be encrypted. (appointment reminders, x-rays, treatment notes, etc.) ***Things like social security number and account information will not be shared, unless with an insurance company, which is encrypted.***

____ Payment is solely the responsibility of the patient or responsible party. We will gladly bill insurance as a service to you, but any nonpayment or partial payment is then the patients responsibility. Nonpayment may result in turning over your account to a collections agency.

I have read the above conditions of treatment and payment and I agree to their content.

Date: Relationship to Patient:

Signature of patient, parent or guardian