810-632-5533

HARTLAND SMILEMAKERS™

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Thank you for allowing us to be part of your health team, in order for us to better work with you and meet your needs, there are a few things we need to know. PLEASE PRINT.

Patient's Full Name ____________________ What do you prefer to be called? ____________
Birth Date ____________________ Social Security No. ____________________
Phone No. ______________ Cell No. ____________ E-mail ______________
Home Address ____________________ City __________ Zip________ Fax No. __________
Employer ____________________________ Work Phone No. ______________
Address ____________________________
Patient's Dental Insurance ____________________________ Group No. ____________
Address of Insurance ____________________________ Insurance Phone No. ____________
Spouse's Name ____________________ Social Security No. ____________ Birth Date ________
Employer & Phone No. ____________________________________
Name of Spouse's Dental Insurance (if different) ____________________ Group No.____________
Address of Insurance ____________________________ Insurance Phone No. ____________
Whom may we thank for recommending us? ____________________________

MEDICAL HISTORY

Medical doctor's name, address ____________________________
Are you under a doctor's care now? Why? ____________________________ YES NO
Have you been hospitalized during the past two years? Why?____________________ YES NO
Are you taking any medications, pills, or drugs? What? ____________________ YES NO
Are you allergic to any medications, metals or materials? What? ______________ YES NO
Are you pregnant? (women) ____________________________ YES NO

Please **CIRCLE** if you have had any of the following:

Heart Trouble	Chest Pain	Scarlet Fever	Cancer	Hypoglycemia
High Blood Pressure	Shortness of Breath	Asthma	Thyroid Disease	Psychiatric Care
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Hay Fever	Parathyroid Disease	Drug Addiction
Heart Murmur	Fainting or Dizziness	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Rheumatic Fever	Stroke	Emphysema	Chemotherapy/Radiation	Hemophilia
Congenital Heart Lesion	Diabetes	Frequent Cough	Arthritis/Gout	AIDS
Artificial Heart Valve	Excessive Thirst	Lung Disease	Rheumatism	Venereal Disease
Heart Pacemaker	Artificial Joints/Hips	Tuberculosis	Pain in Jaw or Joints	Cold Sores
Heart Surgery	Kidney Trouble	Liver Disease	Cortisone Medicine	Fever Blister
Blood Disease	Ulcers	Hepatitis A (infec.)	Glaucoma	Herpes
Anemia	Allergies	Hepatitis B (serum)	Epilepsy or Seizures	Bruise
☐ None of the above		Yellow Jaundice	Nervousness	Sickle Cell Anemia

Have you ever had any other serious illness not circled above? Please describe in detail ____________________

FINANCIAL INFORMATION

Our office policy requires that your obligation (or **ESTIMATED** insurance copayment) be paid by the time treatment is completed. Please advise our receptionist if other arrangements are necessary, **BEFORE SEEING THE DOCTOR**. We will be happy to help you **ESTIMATE** your copayment based upon our previous experience of what a particular Insurance Company has paid in the past. **WE CANNOT GUARANTEE THAT YOUR DENTAL PLAN WILL PAY ANY OR ALL OF YOUR BALANCE**. In all cases, balances remaining after insurance has paid will be billed to you. We accept cash, personal checks on local banks, money orders, VISA, Master Card, Discover and Care Credit.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST BY MY INSURANCE CARRIER FOR SERVICES RENDERED.
I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION NECESSARY TO PROCESS CLAIMS.
I AGREE TO BE RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY DENTAL PLAN

Signature ____________________________ Date ______________

-PLEASE CONTINUE ON PAGE 2-

DENTAL HISTORY

Are you having any pain or discomfort? Please explain. ______________________________

Do you have any questions or concerns about your health? ______________________________

When was your last dental visit, what was done? ______________________________

What was your reason for leaving your former dentist? ______________________________

Are you nervous about seeing the dentist? ______________________________

Have you ever been shown how to brush, floss, clean teeth, gum & tongue? ______________________________

Are you interested in using nitrous oxide______________ or head phones______________ during treatment?

PRE CLINICAL INTERVIEW

1. What can I do for you today? ______________________________
2. How often do you go to the dentist? ______________________________
3. Have you lost any permanent teeth?__________ Why?____________________ How long ago? __________
4. Have missing teeth been replaced?__________ Fixed bridge?__________ Removable bridge?__________ Denture? ____
5. Were replacements discussed?__________ Have you ever wondered about replacements?______________
6. How often do you brush your teeth?____________________ p.m. ______________
7. Do you brush before or after breakfast?__________ If before, why? ______________________
8. Do you use dental floss? ______________________________
9. Do your gums ever bleed?______________ When? ______________________________
10. Do your gums ever feel irritated, tender or swollen? ______________________________
11. Does food get caught between your teeth when you chew?__________ Where?______________________
12. Do you ever have an unpleasant taste in your mouth that you feel might be coming from your teeth or gums? __________
____
13. Do you smoke?__________ How much?______________________________
14. Are you aware of any areas of swelling or irritation in or around your mouth?______________________
    Where? ______________________________
15. Do you have pain in any of your teeth because of heat?__________ Cold?__________ Sweets?__________ Or pressure?___
    Where? ______________________________
16. Can you chew evenly on both sides of your mouth?______________ Do you favor one side? ______________
17. In your opinion, what is the overall condition of your teeth?____________________ Gums?______________
18. What have other dentists told you about your teeth and gums?______________________________
19. Are you pleased with the appearance of your teeth? ______________ Would you like whiter teeth? ______________
20. Did your parents lose their teeth?__________ Why?______________________________
21. Do you or any member of your family have a problem with snoring?______________________________
22. What do you expect from your dentist? ______________________________

THANK YOU for filling out this form. If you should ever have any questions, please feel free to ask any of our health team members.