



**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 (infect.)	Glaucoma	Herpes
Anemia	Allergies	Hepatitis B (serum)	Epilepsy or Seizures	Bruise
<input type="checkbox"/> 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 \_\_\_\_\_

## 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.