smalldental

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact:

Name: _____ Relationship: _____

Cell Phone: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

DENTAL INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Dental Insurance

◯ Primary & Secondary Dental Insurance

Name of Primary Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group #: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Name of Secondary Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group #: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

I certify that I am covered by the above insurance company and I assign directly to Dr. Small and all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I also certify that if insurance is not considered, I am responsible for the total cost of services rendered.

_____ _____ _____

Patient / Guardian Name Patient / Guardian Signature Date

KAITLIN C. SMALL D.M.D

133 Franklin Corner Road, Lawrenceville, NJ 08648

Phone: (609)-896-0529 **Website:** https://smalldental.com/ **Email:** smalldentaloffice@gmail.com

smalldental

Date : _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____ have received a copy of this office's Notice of Privacy Practices.
First & Last Name

_____
Please print name

_____
Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because of the following reason:

- ◯ Individual refused to sign
- ◯ Communication barriers prohibited obtaining the acknowledgement
- ◯ An emergency situation prevented us from obtaining acknowledgement
- ◯ Other (Please Specify below)

_____

_____

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Full Name: _____

Date: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? ◯ Yes ◯ No If yes, where? _____

Do you require antibiotics before dental work? ◯ Yes ◯ No If yes, why? _____

Have you experienced problems associated with previous dental work? ◯ Yes ◯ No

Do you now or have you experienced pain/discomfort in your jaw (TMJ/TMD)? ◯ Yes ◯ No

Your current dental health is: ◯ Good ◯ Fair ◯ Poor

Do you floss daily? ◯ Yes ◯ No Do you brush daily? ◯ Yes ◯ No

Have you ever had periodontal disease? ◯ Yes ◯ No

Do your gums bleed when brushing? ◯ Yes ◯ No

How often do you replace your toothbrush? _____

Would you like fresher breath? ◯ Yes ◯ No Whiter teeth? ◯ Yes ◯ No

Do you have mobility in your teeth? ◯ Yes ◯ No

Are you happy with how your smile looks? ◯ Yes ◯ No

If no, what would you change? _____

MEDICAL HISTORY

Do you have a personal care physician? ◯ Yes ◯ No

If yes, Physician's Name: _____

Office Address: _____

Phone Number: _____ Date of last visit: _____

Are you currently under the care of a physician for medical issues? ◯ Yes ◯ No

If yes, please explain: _____

Do you smoke or use tobacco in any form? ◯ Yes ◯ No

Are you allergic to any of the following?

Aspirin	Codeine	Erythromycin	Iodine	Seasonal Allergies	Tetra
Amoxicillin	Clindamycin	Jewelry/Metals	Latex (Rubber)	Sedatives	
Barbiturates	Dental Anesthetics	Hay Fever	Penicillin	Sulfa Drugs	

Please list additional drugs/materials that cause allergic reactions:

_____

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

_____ _____ _____

Patient / Guardian Name Patient / Guardian Signature Date

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Date : _____

MEDICAL HISTORY CONTINUED

Are you taking any of the following?

Acetaminophen	Blood Thinners	Recreational Drugs	**List Additional Medications Below**
Antibiotics	Cold Remedies	Steroids/Cortisone	_____
Antihistamines	Disitalis/Heart Medication	Thyroid Medication	_____
Aspirin	Insulin/Diabetes Drugs	Tranquilizers	_____
Blood Pressure Medication	Nitroglycerine		_____

Have you ever taken Phe-Fen (Redux or Pondimin)? ◯ Yes ◯ No

Have you ever taken Fosamax or any other Bisphosonate? ◯ Yes ◯ No

Are you currently taking any prescription, over the counter drugs, herbal remedies, vitamins, and or minerals not listed above? If yes, please list below.

_____

Do you have artificial joints? ◯ Yes ◯ No If yes, what joints and from when? _____

For women only:

Are you taking birth control? ◯ Yes ◯ No Are you pregnant? ◯ Yes ◯ No ◯ Unsure

Are you nursing? ◯ Yes ◯ No

Have you ever had any of the following diseases or medical problems? Please circle what applies.

Abnormal Bleeding	Colitis	Hay Fever	Liver Disease	Sinus Problems
Alcohol Abuse	Depression	Headaches	Lupus	Snoring
Anemia	Diabetes	Heart Attack	Mitral Valve Prolapse	Steroid Therapy
Anxiety	Difficulty Breathing	Heart Murmur	Osteoporosis	Stroke
Arthritis	Drug Abuse	Heart Surgery	Pacemaker	Tonsilitis
Artificial Valves	Emphysema	Hemophilia	Radiation	Tuberculosis
Asthma	Epilepsy	Herpes	Rheumatic Fever	Ulcers
Blood Transfusion	Fainting Spells	Hepatitis	Scarlet Fever	Venereal Disease
Cancer	Fever Blisters	High Blood Pressure	Seizures	
Chemotherapy	Glaucoma	Low Blood Pressure	Shingles	
Chicken Pox				

Do you snore? ◯ Yes ◯ No Do you have sleep apnea? ◯ Yes ◯ No Do you use: C-PAP or Oral Appliance

Have you been hospitalized for any reason in the past five years? If so for what and when?

_____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____ _____ _____

Patient / Guardian Name | Patient / Guardian Signature | Date

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