Natural Smiles

Date_____ Name_____
First *MI* *Last*

Address_____
Street *City* *St* *Zip*

Main Phone# (_____)_____ Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single

Birth Date: _____/_____/_____ Soc. Sec. #_____ Preferred Name:_____
(if different from above)

Email Address:_____*(used for patient communication/business only)*

Employer Information: ☐ Retired ☐ Employed by: _____

_____ Work Phone# (_____)_____
Employer's Address *City* *Zip*

Insurance Information: Do you have Dental Insurance? Yes No

If "YES", please provide your insurance card for a photocopy.

If you do not have a card, Please fill in as much information below as possible to assist us in learning of any available benefits you may have.

☐ I am the subscriber ☐ I am the dependant (Subscriber's Name)_____
First *Last*

Subscriber's Soc Sec or ID #_____ Subscriber's Birth Date _____/_____/_____

Insurance Name _____ Group Name _____

Group # _____ Insurance Benefit Phone Number _____

Health Information

Do you currently use tobacco products? Yes No

Do you wear dentures/partials now? Yes No if "yes", how old is the most current one? _____

Do you have a personal Dentist? Yes No Dentist's Name_____

Do you have a personal Physician? Yes No Physician's Name _____

Have you been instructed by a physician to have antibiotics prior to any dental appointment? Yes No

Are you currently on any blood thinning medication? Yes No

Do you have problems with a dry mouth? Yes No

Please list any prescription medications you are currently taking. A current list to photocopy is acceptable.

_____

Turn over to complete the Patient Health Record

Please mark below if you have or have had any of the following:

_____ Anemia
_____ Allergies:
_____ Aspirin
_____ Codeine
_____ Erythromycin
_____ Latex
_____ Penicillin
_____ Tytracycline
_____ Other _____
_____ Artificial Joints
_____ Arthritis _____
_____ Asthma
_____ Alzheimer's / Dementia / Memory Loss
_____ Blood Pressure ~ High
_____ Blood Pressure ~ Low
_____ Blood disease
_____ Cold Sores
_____ Congenital Heart Defect
_____ Other _____

_____ Difficulty Breathing
_____ Drug/Alcohol Abuse
_____ Dry Mouth
_____ Emphysema
_____ Epilepsy / Seizures / Fainting
_____ Excessive Bleeding
_____ Fibromyalgia
_____ Heart Murmur
_____ Hemophilia
_____ Herpes
_____ Heart Attack
_____ Hepatitis A B C
_____ HIV +/ Aids
_____ Kidney Disease
_____ Nervous Problems
_____Headaches ~ Chronic
_____ Cough Persistent
_____ Cancer

_____ Rheumatic Fever
_____ Shortness of Breath
_____ Thyroid Problems
_____ TMJ Problems
_____ Tuberculosis
_____ Tumors
_____ Ulcers
_____ Radiation Treatment
_____ Parkinson's Disease
_____ Pacemaker
_____ Surgery of Mouth
_____ Stroke
_____ Stomach Problems
_____ Skin Rash
_____ Sinus Problems
_____ Circulatory Problems
_____ Chemotherapy

Please list any current medications you are taking: _____

_____

_____

_____

Referral Information: Whom may we thank for referring you t our practice?

☐ Another Patient ☐ Dental Office ☐ Phone Book ☐ TV ☐ Internet
☐ News Paper ☐ Other _____

Name of Person *or business that referred you to our practice*?_____

Authorization & Release

I have read and answered the above questions to the best of my knowledge. If I choose to have treatment, I understand I am financially responsible for all charges.

If I have insurance benefits, I authorize my insurance company to pay directly the Denturist/Dentist the benefits otherwise payable to me. I authorize the release of all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of this signature on all insurance claims and *acknowledge with my signature that I have been offered a copy of Natural Dentures (Holden Holdings, PC) and its in-house affiliate's Privacy Policy*.

I give permission for interns/externs to work directly with me and on my treatment as they are being overseen by a qualified and approved interning/externing supervisor. If I have any concerns or wish not to be seen by one, I will inform the supervisor on site of that decision.

_____ _____
Patient (authorized) Signature Date