

## **PATIENT INFORMATION**

6161 Transit Road • East Amherst 4007 Harlem Road • Snyder 157 Main Street • Tonawanda

716 • 42 • SMILE

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Tast Name	_ Responsible Party	(if not patient)							
Name	First Name:	ame:	ne:						
None Phone	Address:				Address 2:				
Soc Secondary   Soc Secondar	City, State, Zip:								
Responsible Party is also a Policy Holder for Patient    Patient Information=  Patient	Home Phone:		Work Phone	:	Ex	t:	Cellular:		
Patient   Information:	Birth Date:	Date: Soc Sec:				Drivers Lic	: 		
Patient   Information:	Responsible Pa	arty is also a Policy H	older for Patier	nt Primary Ins	surance Policy	Holder	Secondary In	ısurance Policv H	older
State   Stat	<u>-</u>								
Note	Address:				Address 2:				
Marie   Mari	City:			State:			Zip:		
Mage	Home Phone:		_Work Phone:		Ext	:	Cellular:		
Refine Date   Ref	Sex: Male	Female		Marital Status:	Married	Single	Divorced	Separated	Widowed
Employment Full Time Part Time Retired  Status: Student Full Time Part Time  Employer: Occupation:	Birth Date:			Soc. Sec:		Drive	ers Lic:		
Employment Full Time Part Time Retired   Additional Comments:	·	<del>-</del>							
Status: Student Full Time Part Time Employer: Occupation:  Pharmacy: Phone: Emergency Contact: Phone:  Primary Insurance Information  Name of Insured: Insured Birth Date: Insured Birth Date: City, State, Zip: City, State, Zip: Relationship to Insured: Self Spouse Child Other  Secondary Insurance Information  Relationship to Insured: Self Spouse Child Other  Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other  Address: Address: Address: Self Spouse Child Other  Secondary Insurance Information  Name of Insured: Oo Rem. Deduct: Oo  Secondary Insurance Information  Name of Insured: Relationship to Insured: Self Spouse Child Other  Insured Soc. Sec: Insured Birth Date: Self Spouse Child Other									
Employer: Occupation: Phone: Emergency Contact: Phone: Employer: Employer: Insured Birth Date: Employer: Insured Birth Date: Employer: Insured Birth Date: Employer: Insured Birth Date: Employer: Employe	Employment	Full Time	Part Time	Retired		Add	litional Comme	nts:	
Pharmacy: Phone: Phone: Phone: Phone: Phone: Phone: Phone: Phone:	Status: Student	Full Time	Part Time						
Pharmacy: Phone:	Employer:		Occupatio	n:		_			
Emergency Contact: Phone: Primary Insurance Information  Name of Insured: Relationship to Insured: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Insured Birth Date: Address: Address 2: Address 2: City, State, Zip: City, State, Zip: Rem. Benefits: 00 Rem. Deduct:	Dharmacu:		•						
Primary Insurance Information  Name of Insured:  Insured Birth Date:  Employer:  Address 2:  City, State, Zip:  Relationship to Insured:  Address 2:  City, State, Zip:  Employer:  Insured Birth Date:  Relationship to Insured:  Address 2:  City, State, Zip:  Rem. Benefits:  Name of Insured:  Insured Birth Date:  Insured Birth Date:  Employer:  Insured Birth Date:  Insured Birth Date:  Employer:  Address 2:  Insured Birth Date:  Insured Birth Date:  Employer:  Address 2:  Address 2:  Insured Birth Date:  Employer:  Address 2:  Address 2:  Insured Birth Date:  Employer:  Address 2:  City, State, Zip:  Insured Birth Date:  Insured									
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Insured Soc. Sec: Insured Birth Date: Ins. Company: Address: Address 2: Address 2: City, State, Zip: City, State, Zip: Secondary Insurance Information  Name of Insured: Relationship to Insured: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Employer: Ins. Company: Address 2: City, State, Zip: City, Sta	Primary Insurance	Information							
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Address:	Insured Soc. Sec: _	Insured Birth Date:							
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City,State,Zip: City,State,Zip:									



## MEDICAL HISTORY

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_

6161 Main Street • East Amherst 4007 Harlem Road • Snyder 157 Main Street • Tonawanda

DATE

716 • 42 • SMILE

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PATIENT NAME \_\_ \_ Birth Date \_\_\_ Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you under a physician's care now? Yes  $\bigcirc$  No  $\,$  If yes, please explain: Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: Have you ever taken Fosamax, Boniva or Actonel? Yes No If yes, please explain: Are you on a special diet? Yes No If yes, please explain: Do you use tobacco? Yes No If yes, please explain: \_\_\_ Do you use controlled substances? O Yes No If yes, please explain: \_ Women: Are you Pregnant or trying to be? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Penicillin Local Anesthetics Acrylic Metal Sulfa drugs Aspirin Codeine Latex Other If yes, please explain: Do you have, or have you had, any of the following? AIDS/HIV Positive Hemophilia Hepatitis 🔾 Yes 🔘 No Cortisone Medicine **Radiation Treatments** 🔾 Yes 🔘 No Yes O No Alzheimer's Disease Yes No Diabetes Yes ( ) No A Hepatitis B or C Recent Weight Loss ○ Yes ○ No **Drug Addiction** Yes ( ) No Renal Dialysis Anaphylaxis Hernes Rheumatic Fever Yes No Easily Winded Yes ( ) No High Blood Pressure ○ Yes ○ No Yes ( ) No Anemia Rheumatism  $\bigcirc$  Yes  $\bigcirc$  No Angina ○ Yes ○ No Emphysema Yes O No High Cholesterol Yes O No O Yes O No O Yes O No Scarlet Fever  $\bigcirc$  Yes  $\bigcirc$  No Yes 🔘 No Arthritis/Gout **Epilepsy or Seizures** Hives or Rash Excessive Bleeding Yes No Excessive Thirst Fainting Yes No  $\begin{array}{cccc} \mbox{Hypoglycemia} & \mbox{$\stackrel{\frown}{\bigcirc}$ Yes $\stackrel{\frown}{\bigcirc}$ No} \\ \mbox{Irregular Heartbeat} & \mbox{$\stackrel{\frown}{\bigcirc}$ Yes $\stackrel{\frown}{\bigcirc}$ No} \end{array}$ Shingles Artificial Heart Valve Yes ( No Yes O Yes O No Sickle Cell Disease Artificial Joint Yes ( ) No Sinus Trouble Yes No O No Yes
 ✓ Yes
   Yes
 Asthma Spells/Dizziness Kidney Problems Spina Bifida **Blood Disease** Yes No Frequent Cough Yes No Leukemia Yes ( ) No Stomach/Intestinal Disease **Blood Transfusion** Yes No Frequent Diarrhea Liver Disease Yes No Ves Stroke  $\bigcirc$  Yes  $\bigcirc$  No Low Blood Pressure O Yes O No O Yes No **Breathing Problem** ○ Yes ○ No Frequent Headaches Swelling of Limbs  $\bigcirc$  Yes  $\bigcirc$  No Genital Herpes  $Yes \ \bigcirc \ No$ Yes No **Bruise Easily** ○ Yes ○ No Lung Disease O No Thyroid Disease Yes O No Yes No Mitral Valve Prolapse Ves Cancer Yes O No Glaucoma Tonsillitis O No Yes Chemotherapy Yes No Hav Fever Osteoporosis Tuberculosis ◯ Yes ◯ No Yes No Yes No O Yes O No Heart Attack/Failure Pain in Jaw Joints Chest Pains **Tumors or Growths Ulcers** Yes No Cold Sores/Fever Blisters ( ) Yes ( ) No Parathyroid Disease ( ) Yes ( ) No Heart Murmur Venereal Disease Yes No Congenital Heart Disorder Yes No Heart Pacemaker Heart ○ Yes ○ No Psychiatric Care Yes No Yellow Jaundice ( ) No Yes ( ) No Convulsions ○ Yes ○ No I Trouble/Disease Have you ever had any serious illness not listed above? Yes No Comments: I affirm the information given is true to the best of my knowledge. I certify I have dental insurance as listed above and assign benefits directly to Better Smile of WNY Dentistry, its owner and associates. Better Smile of WNY may use my health care information and disclose information for purposes of obtaining payment and determining benefits. I authorize use of my signature on all insurance claims.