SMILE INSTITUTE
OF FAMILY DENTISTRY

WELCOME TO THE SMILE INSTITUTE OF FAMILY DENTISTRY

7712 West Good Hope Road Milwaukee, WI 53223
PHONE: (414) 760-2000 // EMAIL: office@sifamilydentistry.com
WEBSITE: www.sifamilydentistry.com

SO THAT WE MAY PROCESS YOUR ACCOUNT AND/OR INSURANCE CORRCTLY, PLEASE COMPLETE THIS PATIENT ACCOUNT REGISTRATION FORM

WHO IS RESPONSIBLE FOR THIS ACCOUNT: *circle one* - MR MRS. MS. MISS DR

NAME: _____ PATIENT ACCOUNT REGISTRATION

ADDRESS:	DOB:
CITY/STATE:	SSN:
ZIPCODE:	EMPLOYER:
HOME PHONE:	WORK PHONE:
CELL PHONE:	EMAIL:
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:

HOW DID YOU HEAR ABOUT US?

- Friend or Relative
- Google
- Facebook or Instagram
- Insurance Company
- Other:_____

*Your insurance policy is a contract between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at time of service. We accept cash, debit/credit cards, HSA/FSA cards, and Care Credit. Any missed appointments without 24 hours notice will result in a charge to the patient. These charges are due and payable within 30 days. I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment if services NOT covered by insurance benefits.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____DATE_____

MEDICAL HISTORY – So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information will remain confidential.

PATIENT NAME:	AGE:	WEIGHT:
MALE / FEMALE	DOB:	HEIGHT:

ADDRESS IF DIFFERENT THAN ACCT HOLDER and/or UPDATED:
_____
_____

*If you are completing this form for another person, what is your relationship to that person?

YOUR NAME:	RELATIONSHIP:

MEDICAL HISTORY

PHYSICIAN'S NAME & ADDRESS: _____
_____

Are you now under the care of a physician? **Yes / No**
If yes, for what reason? _____

Are you presently taking any medications / drugs / pills? **Yes / No**

List all medications prescribed by your physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances.

_____
_____
_____
_____

ALLERGIES / SENSITIVITES

Are you allergic/sensitive (or ever had adverse reaction) to:
CHECK ALL THAT APPLY OR CHECK NONE
O PENICILLIN
O ASPIRIN
O CODEINE
O OTHER ANTIBIOTICS
O LOCAL ANESTHETIC
O METALS
O OTHER MEDICATIONS/SUBSTANCES
O **NONE**

WOMEN: Are you pregnant or suspect that you may be? **YES / NO**
Are you nursing? **YES / NO**

Do you have, or have you ever had any of the following: (YES or NO)

Artificial (prosthetic) Heart Valve	Y	N	Anorexia	Y	N	Drug dependency	Y	N	Arthritis / Rheumatism	Y	N
Previous Infective Endocarditis	Y	N	Bulimia	Y	N	Chemical dependency	Y	N	Learning Disability	Y	N
Damaged heart valves in transplanted heart	Y	N	Lung Disease / COPD	Y	N	Alcohol Addiction	Y	N	Mental Health Disorder	Y	N
Congenital Heart Disease (CHD) unrepaired	Y	N	Tuberculosis	Y	N	Liver Disease	Y	N	Hepatitis (circle one) Type A B C Other	Y	N
Cyanctic CHD repaired (completely) in last 6 months	Y	N	Asthma	Y	N	Stroke	Y	N			
Repaired CHD with residual defects	Y	N	Shortness of breath	Y	N	Leukemia	Y	N	Has HPV vaccination been given? Ages 9 y/o and older.	Y	N
Heart Disease / Surgery	Y	N	Respiratory Ailments	Y	N	Cancer	Y	N	Ulcers	Y	N
Heart Murmur	Y	N	Emphysema	Y	N	Tumors	Y	N	Gastrointestinal Disease	Y	N
Heart Pacemaker	Y	N	Sinus Trouble	Y	N	Chemotherapy	Y	N	GERD (gastric reflux)	Y	N
Rheumatic Fever	Y	N	Diabetes Type I or Type II	Y	N	Radiation Therapy	Y	N	Hearing Impaired	Y	N
Mitral Valve Prolapsed	Y	N	Thyroid Problems	Y	N	Sickle Cell Disease	Y	N	Glaucoma	Y	N
High / low blood pressure	Y	N	Persistent Swollen Glands	Y	N	Osteoporosis	Y	N	Cortisone Medication	Y	N
Blood Disorders	Y	N	Kidney Problems	Y	N	Sleep Disorder	Y	N	Fainting Spells	Y	N
Anemia	Y	N	Venereal Disease	Y	N	Neurological Disorders	Y	N	Organ Transplant	Y	N
Prolonged Bleeding	Y	N	HIV Positive / AIDS / ARC	Y	N	Epilepsy	Y	N	Removal of spleen	Y	N
Hemophilia	Y	N	HPV Positive	Y	N	Autoimmune Disease	Y	N	Artificial Joint / Prosthesis	Y	N

BISPHOSPHONATES

Have you ever or are you currently taking any of the medications: alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for **osteoporosis** for Paget's disease? **YES / NO**
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **YES / NO** Date Treatment Began: _____

BLOOD PRESSURE
/

Have you ever or do you currently smoke? **YES / NO** -- Cigarettes / Cigars / Chew / Pipe / Vape / Marijuana / K2 / Hookah / Other _____
How much? _____ How often? _____ When did you quit? _____
Do you drink alcoholic beverages? **YES / NO** -- How much? _____ How often? _____
Have you had any other serious illness, hospitalization or accident? **YES / NO**
If yes, please explain: _____

Doctor Comments:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature _____ Date _____
(parent/guardian)

Doctor Signature _____ Date _____

DENTAL HISTORY – So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this dental history form. This information will remain confidential.

What is the reason for your visit today? _____

Previous Dentist's Name & Address: _____

Date of Last Visit: _____ Last Hygiene Visit: _____ Last X-Rays: _____

How often do you have dental examinations? _____

How often do you brush? _____ How often do you floss? _____

What other aids do you use? (Electric toothbrush, Waterpik, toothpick, etc.) _____

Do you have any dental problems? **YES / NO**

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or Cold	Y	N
Sweets	Y	N
Biting or pressure	Y	N
Have you ever noticed any mouth odors or bad taste?	Y	N
Do you frequently get cold sores, blisters or any lesions?	Y	N
Do your gums bleed or hurt?	Y	N
Have your parents experienced gum disease or tooth loss?	Y	N
Have you noticed any loose teeth or change in your bite?	Y	N
Does food tend to become caught between your teeth?	Y	N
Do you:		
Clench or grind your teeth when you are awake or asleep?	Y	N
Have tired jaws, especially in the morning?	Y	N
Bite your lips or cheeks regularly?	Y	N
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe)	Y	N
Mouth breathe while awake or asleep?	Y	N
Snore?	Y	N
Have you ever experienced?		
Clicking or popping of the jaw?	Y	N
Pain? (joint, ear, side of face)	Y	N
Difficulty opening or closing the mouth?	Y	N
Frequent headaches, neck aches or shoulder aches?	Y	N
Any pain or soreness in the muscles of your face or around the ears?	Y	N

Have you ever had:		
Orthodontic treatment?	Y	N
Oral Surgery?	Y	N
Teeth Removed? If so, have they been replaced? **YES / NO**	Y	N
Fixed Bridge?	Y	N
Removable Partial?	Y	N
Complete Denture?	Y	N
Implants?	Y	N
Are you happy with the replacement?	Y	N
Periodontal Treatment?	Y	N
Gum Surgery? If so, when and by whom?	Y	N
You teeth ground or the bite adjusted?	Y	N

Have you ever had a serious injury to the mouth or head? **YES / NO**
If yes, please describe and include cause:
_____

Do you like the appearance of your teeth/smile? **YES / NO**
Do you like the color of your teeth? **YES / NO**
Are your teeth as straight as you'd like? **YES / NO**

What would you like to change most in the appearance of your teeth?
_____

Do you feel anxiety about having dental treatment? **YES / NO**
Have you ever had an upsetting dental experience? **YES / NO**
If yes, please describe:
_____

How did you overcome your anxiety?
_____

Is there anything else about having dental treatment that you would like us to know?
_____
_____

Doctor Comments:

I consent to the doctor's exam and necessary diagnostics for treatment, including x-rays.

Patient Signature _____ Date _____
(parent/guardian)

Doctor Signature _____ Date _____