Smile Shop Dental
General Family & Implant Dentistry

10960 S. Eastern Ave., Ste. 112
Henderson, NV 89052
(702) 444-7771
www.smileshopdental.com

PATIENT INFORMATION

Name: Last _____ First _____ MI _____ ☐ Male ☐ Female

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. How do you wish to be addressed? _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Do you prefer to be contacted for appointment confirmation via email or phone? _____

Date of Birth: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Who may we thank for referring you to our practice? _____

DENTAL INSURANCE - PRIMARY

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Subscriber SSN / ID#: _____

Group/Employer Name: _____ Group Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

DENTAL INSURANCE – SECONDARY

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Subscriber SSN / ID#: _____

Group/Employer Name: _____ Group Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

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ASSIGNMENT AND RELEASE

- I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims of benefits.
- I authorize payment of insurance benefits directly to Smile Shop Dental.
- I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.
- I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.
- I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental insurance benefits.

Patient/Guardian Signature: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____ Date: _____

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MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____ Date of Last Visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If Yes, please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Do you have any metal rods, pins, or implants placed? ☐ Yes ☐ No If Yes, date: _____

Do you have a history prosthetic material used for cardiac valve repair? ☐ Yes ☐ No

Do you have a history of infective endocarditis (infections of the heart)? ☐ Yes ☐ No

Do you have a history of a cardiac transplant that developed into complications with valves? ☐ Yes ☐ No

Do you have a history of congenital heart disease? ☐ Yes ☐ No

If Yes, please indicate treatment, if any_____

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever had any surgical procedures? ☐ Yes ☐ No

If Yes, please explain with year of procedure: _____

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Sickle Cell Disease
☐	☐	Alcohol Abuse	☐	☐	HIV+ AIDS	☐	☐	Sinus Problems
☐	☐	Allergies**	☐	☐	Heart Attack	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Thyroid Problems
☐	☐	Angina Pectoris	☐	☐	Heart Surgery	☐	☐	Tuberculosis

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Yes	No	Conditions	Yes	No	Conditions
☐	☐	Arthritis	☐	☐	Hepatitis A
☐	☐	Asthma	☐	☐	Hepatitis B
☐	☐	Blood Transfusion	☐	☐	Hepatitis C
☐	☐	Cancer	☐	☐	High Blood Pressure
☐	☐	Chemotherapy	☐	☐	Joint Replacement
☐	☐	Colitis	☐	☐	Kidney Problems
☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Difficulty Breathing	☐	☐	Low Blood Pressure
☐	☐	Drug Abuse	☐	☐	Mitral Valve Prolapse
☐	☐	Emphysema	☐	☐	Pace Maker
☐	☐	Epilepsy	☐	☐	Psychiatric Problems
☐	☐	Facial Surgery	☐	☐	Radiation Therapy
☐	☐	Fainting Spells	☐	☐	Rheumatic Fever
☐	☐	Fever Blisters	☐	☐	Seizures
☐	☐	Frequent Headaches	☐	☐	STD's
☐	☐	Hemophilia	☐	☐	Shingles
			☐	☐	Ulcers

**Please Circle Any Allergies

Aspirin
Codeine
Dental Anesthetics
Erythromycin
Penicillin
Tetracyclin
Jewelry
Latex
Metals
Other: _____

If Female, please answer:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, # weeks: _____

Are you nursing? ☐ Yes ☐ No

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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DENTAL HISTORY

How may we help you today? _____

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

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever had pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Have you ever suffered trauma to your teeth or face? ☐ Yes ☐ No

Are you under stress? (new job, moving, relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color or shade of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or sweets? ☐ Yes ☐ No

Have you ever had a serious or difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had a bad experience at the dental office? ☐ Yes ☐ No

When was your last dental cleaning? _____ Last Dental Visit? _____

Why did you leave your previous dentist? _____

Here at Smile Shop Dental we offer a wide variety of services to enhance and keep your beautiful smile. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers or Other Cosmetics	OTHER :
Clear Correct Invisible Aligners (Orthodontics)	Crown and Bridge	
Sealants	Dental Implants	
Dentures / Partials	Night / Sports Guards	