Strongsville Smile Keepers

**Patient Information**

NAME Last _____ First _____ MI ___ Preferred Name _____

M/F ____ Married ____ Single ____ Child ____

Date of Birth _____ SS#_____

Home Phone _____ Cell Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Email _____

Who referred you? Family member ☐ Friend ☐ Coworker ☐ Name:_____

Where have you seen us? Google ☐ Facebook ☐ Website ☐ Newspaper ☐ Movies ☐ Other:_____

Employer Name: _____ Employer Phone: _____

**Responsible Party Information**

NAME Last _____ First _____ MI ___

Relationship to Patient _____ Date of Birth _____ SS#_____

Home Phone _____ Cell Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Email _____

Employer Name _____ Address _____

City _____ State _____ Zip _____

**Primary Insurance**

Name of Insured _____ Date of Birth _____ SS# _____

Insurance Carrier _____ Subscriber ID _____

Group Plan _____ Group # _____

Address _____ City _____ State _____ Zip _____

**Secondary Insurance**

Name of Insured _____ Date of Birth _____ SS# _____

Insurance Carrier _____ Subscriber ID _____

Group Plan _____ Group # _____

Address _____ City _____ State _____ Zip _____

## Medical History

**Circle all that apply**

| | | | |
|---|---|---|---|
| Acid Reflux/ GERD | ADHD/Autism | Alcoholism | Alzheimer's |
| Anemia | Anxiety Disorders | Arthritis | Artificial Joints |
| Asthma | BC/Hormone Therapy | Bisphosphonates | Blood Thinners |
| Cancer | Cerebral Palsy | Chemo/Radiation | Cholesterol |
| COPD | Diabetes | Epilepsy | Excessive Bleeding |
| Glaucoma | Hay Fever | Head Injuries | Heart Disease |
| Heart Murmur | Hepatitis | High Blood Pressure | HPV |
| Kidney Disease | Leukemia | Liver Disease | Low Blood Pressure |
| Macular Degeneration | Mental Disorders | Mitral Valve Prolapse | Multiple Sclerosis |
| Nervous Disorders | Osteoporosis | Pacemaker | Pregnancy |
| Premedicate | Radiation Treatment | Respiratory Problems | Rheumatic Fever |
| Seizures | Sinus Problems | Smoke | Snore/Sleep Disorder |
| STD | Stomach Problems | Stroke | Thyroid |
| Tuberculosis | Tumors | Ulcers | Vertigo |

Surgery:_____

Medication Allergies:_____

Other:_____

**Do you need to be premedicated with antibiotics for dental procedures? NO / YES**

**Have you recently required medical assistance? NO / YES**

**Explain:_____**

Current Medications: _____

**Authorization and release**

I have filled out this from to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care providers.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

X _____ Date _____

Signature of patient or parent if minor