Karl A. Smith, DDS, LLC

Website: drkarlsmith.com E-mail: info@drkarlsmith.com

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

E-mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Information: _____
Name Phone Relationship

Health Information

Date of last health care exam: _____What was this exam for?_____

Date of last dental exam: _____ What was this exam for? _____

Current General Dentist: _____ Phone: _____

Address: _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial	No	Yes	Unintentional Weight Loss/Gain	No	Yes

Endocarditis					
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle)
Have you ever received a diagnosis of "high blood pressure"? No Yes
What is your normal blood pressure? ____ / ____ Today: ____ /_____ P:

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin, Ibuprofen or Tylenol …..…… No Yes
d. Codeine, Valium® or other sedatives…… No Yes
e. Latex or Metals…… No Yes
f. Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

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 change in my health and medication.

_____ _____ _____

Patient (Print Name) ***Patient Signature*** ***Date***

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

_____ _____ _____

Doctor (Print Name) ***Doctor Signature*** ***Date***

Referral Information

Whom may we thank for referring you to our practice? ☐ Dental Office ☐ Another patient: friend/relative

Name of person or Doctor's office referring you to our practice: _____

☐ Care to Share Referral ☐ Your Health Magazine ☐ Direct Mail to your Home or Business

☐ Recommendation website such as DoctorOogle or Locateadoc or Yelp.com

☐ Insurance Plan Book or Insurance Website ☐ Sign/Drove by Office

☐ Have been seen by Dr. Smith before (returning) ☐ Found us on drkarlsmith.com

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment ☐ parent or guardian of a minor child

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

The following is for: ☐ the patient ☐ the patient's spouse or domestic partner ☐ parent or guardian of a minor child

Name of Insured: _____
Last First MI

Insured's Social Security Number: _____ Birth Date: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Carrier or Plan Name:_____

Address: _____
Street City State Zip Code

Insured ID #: _____ Group #: _____

**** We make every effort to coordinate your dental benefits for you. There are no guarantees of any payments regardless of estimates

Signature on File

Please check all that apply.

☐ I authorize use of this form on all my insurance submissions.
☐ I authorize release of information to all my Insurance Companies.
☐ I understand that I am responsible for my bill.
☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
☐ I authorize payment direct to my doctor.
☐ I permit a copy of this authorization to be used in place of the original.
☐ I authorize the use of radiographs, study models, pictures and/or videotapes of my case for presentations or publications of the doctor.

Please Print Your Name: _____

Signature: _____ Date:_____