FOSTER SMILES

"Our family treating your family"

Thank you for visiting our office! We want your visit to be pleasant and comfortable. Please assist us by completing this form *entirely*. PLEASE print.

Patient Information:

Name: _____
Last First Middle Initial Preferred Name

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Date of Birth: _____ Driver's License: _____

Social Security Number: _____-_____-_____ E-mail: _____

Preferred Contact Number: (____) _____-_____ (circle) : Home Cell Work

Alternate Contact Number: (____) _____-_____ (circle): Home Cell Work

Emergency Contact Name: _____ Phone: (_____) _____-_____

Relationship of Emergency Contact: _____

Foster Smiles has my permission to (please check):

_____ leave voicemails or texts messages on the phone numbers I've provided

_____ contact me via e-mail for appointment reminders

If patient is under 18 years of age, Responsible Party Name: _____

Address: _____ Phone: (_____) _____-_____

Relation to Patient: _____

Insurance Information:

Primary Dental Carrier Company Name: _____
Insurance Carrier's Phone: (_____) _____-_____
Name of Subscriber: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Relation to Patient: _____
Group Number: _____ ID Number: _____

Secondary Dental Carrier Company Name: _____
Insurance Carrier's Phone: (_____) _____-_____
Name of Subscriber: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Relation to Patient: _____
Group Number: _____ ID Number: _____

PATIENT NAME: _____ DOB: _____

DENTAL HISTORY:

What is the main reason for your visit today?

□ Tooth Pain □ Dental Implants □ Dentures
□ Check-Up □ Extractions □ Veneers/Improve Smile
□ Cleaning □ Braces □ Other: _____

Date of Last Cleaning/Hygiene Visit: _____

Reason for leaving your last Dentist _____

Do you clench your teeth or often wake up with a headache or tenderness in your jaw?□ Yes □ No

How did you hear about our office? □ a friend or existing patient (name) _____

□ social media □ insurance website □ driving by □ Google □ other: _____

MEDICAL HISTORY: (Check all relevant conditions)

□ Bleed excessively
□ Alcohol/Drug Abuse
□ Anemia
□ Angina (chest pain)
□ Artificial Heart Valve
□ Asthma
□ Blood Transfusion
□ Cancer
Type: _____
Date diagnosed
_____
□ Chemotherapy
□ Diabetes
□ Difficulty Breathing
□ Epilepsy/Seizures
□ Fainting
□ Fever Blisters
□ STD
□ HIV/AIDS
□ Mitral Valve Prolapse
□ Heart Attack
Date:_____
□ Heart Surgery
*Date:*_____
□ Heart Disease
□ Hepatitis
Type:_____
□ High Blood Pressure
□ Joint Replacement
Type: _____
Date: _____
□ Kidney Problems
□ Liver Disease
□ Pacemaker/Defibrillator
□ Psychiatric Disorders
□ Radiation Therapy
□ Rheumatoid Arthritis
□ Osteoporosis
(list any Rx you've taken for Osteoporosis)
□ Shingles
□ Sickle Cell
□ Sinus Problems
□ Stroke
□ Hypothyroid
□ Hyperthyroid
□ Tuberculosis
□ Tobacco use

ALLERGIES:

□ Aspirin
□ Anesthetics
□ Sulfa
□ Penicillin
□ Codeine
□ Other: _____

FOR FEMALES:

□ Pregnant? # Weeks: _____
□ Nursing □ Birth Control Pills

Please list any illness not listed above we should be aware of: _____

Medication Name/Dosage	***Frequency***	***Reason for Taking***

IF THERE ARE MORE PRESCRIPTIONS THAN CAN FIT HERE, PLEASE PROVIDE US WITH A HARD COPY OF ALL MEDICATIONS CURRENTLY TAKING and ***ANY PRESCRIPTION*** YOU'VE ***EVER*** TAKEN FOR OSTEOPOROSIS. THANK YOU!

If an employee in this office is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne disease to include Hepatitis B and C and HIV/AIDS.

Treatment Authorization: I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary including the use of local anesthesia or other medication as indicated. I certify the above medical information is accurate to the best of my knowledge.

Patient Signature/Parent or Guardian: _____ **Date:** _____