H RUSHTON SMITH DMD
204 MCFARLAND CIRCLE N
TUSCALOOSA, AL 35406

HEALTH HISTORY AND REGISTRATION

Today's date_____

Patient Information

Patient's Name
Last_____First_____Middle_____Birthdate_____Age_____

If Patient is a Minor, Parent's or Guardian's name_____ E-mail Address_____

Reason for this visit_____ Who May We Thank For Referring You to Our Office?_____

Sex____ Marital____ Social Security Number_____ Employer_____ Years Employed____

Patient's Address_____City_____State_____Zip_____

Home Phone (___)_____Work Phone (___)_____Cell Phone (___)_____

Responsible Party Information

Name Last_____First_____Middle_____Marital_____

Mailing Address_____City_____State_____Zip_____

Home Phone (___)_____Work Phone (___)_____Cell (___)_____

Birthdate_____Social Security Number_____Relation to Patient_____Employer_____

Responsible Party's Spouse

Name Last_____First_____Middle_____Birthdate_____

Employer_____ Yrs. Employed _____Work Phone(___)_____

Emergency Information: Relative Not Living With You

Name _____Relationship to Patient_____Phone(___)_____

Address_____City_____State_____Zip_____

Primary Dental Insurance

Policy Holder's Name _____ birthdate_____

Relation to Patient_____ Effective date_____

Soc. Sec. #_____Group #_____

Contract #_____Phone #_____

Employer_____

Insurance Company_____

Secondary Dental Insurance

Policy Holder's Name_____ birthdate_____

Relation to Patient_____ Effective date _____

Soc.Sec. #_____ Group #_____

Contract #_____Phone #_____

Employer_____

Insurance Company_____

WE WILL NEED A COPY OF YOUR INSURANCE CARD

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This Information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
How long since you have seen a dentist?_____		
Last Complete dental exam, date._____		
Last full mouth X-ray, date._____		
Are you having problems now?	{}	{}
What?_____		
Is your present dental health poor	{}	{}
Do you wear dentures? (Partials or Full)	{}	{}
Are you unhappy with your dentures?	{}	{}
Would you like to know more about Permanent Replacements?	{}	{}
Are you apprehensive about dental treatment?	{}	{}
Have you had any periodontal (gum) treatments?	{}	{}
Do your gums bleed or feel tender or irritated?	{}	{}
Are your teeth sensitive to hot, cold, sweets, Pressure? (Circle)	{}	{}
Are you unhappy with the appearance of Your teeth?	{}	{}
Do you have headaches, earaches, or neck pains?	{}	{}
Have you worn braces on your teeth?	{}	{}
Do you have your 3rd molars (wisdom teeth)?	{}	{}
Do you have discolored teeth that bother you?	{}	{}
Would you like your smile to look better Or different?	{}	{}
Do you regularly use dental floss?	{}	{}

MEDICAL HISTORY	YES	NO
Do you have any current health problems?	{}	{}
Are you under a physician's care now?	{}	{}
For what?_____		
What medications are you currently taking_____		
Are you pregnant?	{}	{}
Do you Smoke?	{}	{}

Circle any of the following which you have had, or presently have:

Heart Disease or Attack	AIDS/ ARC/ HIV positive	Bruise easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Treatment
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

Name of Previous Dentist?_____

City:_____ State:_____

How do you feel about your teeth?_____

Family Physician_____ Phone #_____

Orthodonist _____ Phone #_____

Cardiologist Name _____ Phone #_____

Are You Allergic To Or Have You Reacted Adversely To Any Of The Following Medications?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or Substances_____

If yes, please list_____

Is there any other Medical or Dental information that you feel I should know about?_____

Consent

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge will be added to any overdue balance.

PATIENT Signature (Parent of Child)_____ Date_____

H. Rushton Smith, DMD