

Beautiful Smiles by Robin Santiago,



About You

NAME: _____

_____ Last First MI Mr.
Mrs. Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS# _____

___ Single ___ Married ___ Divorced ___ Partner

Home Address: _____

City State Zip

E-Mail Address: _____

Home#: () _____ Cell#: () _____

Work#: () _____ Ext: _____ Fax#: _____

Where and when are best times to reach you? : _____

Employer: _____

Employer Address: _____

How long there? _____ Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Primary Insurance

Dental Coverage ? _____ Yes _____ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: () _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: ____/____/____ SS#: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary Insurance

Dental Coverage ? _____ Yes _____ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: () _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: ____/____/____ SS#: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Responsible Party Information

Person Responsible for Account: _____

Birthdate: ____/____/____ Relationship: _____

Employer: _____

Work #: () _____ Ext: _____ SS#: _____

Emergency Contact (Relative or Friend not living with you)

His/ Her Name: _____ Relationship: _____

Home #: () _____ Work#: () _____

Payment is due in full at the time of treatment Unless prior arrangements have been approved.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment is expected at the time of service. A finance charge of 1.5% per month, 18% annual rate will be charged on balances 30 days past due. I authorize and request my insurance company to pay to Dr. Santiago directly. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am responsible for any and all collection fees.

Signature _____

Date _____

Medical History

Do you have a personal physician? YES NO

Physician's Name: _____

Phone#:() _____ Date of Last Visit: _____

Your current Physical health is: Good Fair Poor

Are you currently under the care of a physician? YES NO

Please explain: _____

Do you smoke or use tobacco? YES NO

Have you had any metal rods, pins or implants? YES NO

Are you taking any prescriptions/over the counter drugs? YES NO

Please list each one: _____

Have you ever had any of the following diseases or medical problems:

Y N Abnormal Bleeding	Y N Hepatitis
Y N AIDS	Y N Herpes/ Fever Blisters
Y N Alcohol/ Drug Problems	Y N High Blood Pressure
Y N Anemia	Y N HIV
Y N Arthritis	Y N Hospitalized
Y N Artificial Bones/ Joints	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing Y N	Rheumatic/Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease
Y N Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problem
Y N Heart Attack/ Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hemophilia/Blood Disorders	Y N Venereal Disease

Please list any serious Medical Condition (s) that you have ever had:

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metal	Y N Tetracycline
Y N Latex	Y N Dental Anesthetics	

Please list any other drugs/materials that you are allergic to: _____

Authorization and Release of Photographs and Diagnostic Materials

I authorize and release Dr. Santiago to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, education and advertising and marketing. I also authorize Dr. Santiago to use displays intended for promotional purposes without the expectation on any compensation or financial gain.

Signature _____ Date _____



Dental History

Why have you come to the dentist today?

Are you Currently in pain? YES NO

Describe: _____

Do you require Antibiotics before dental treatment? _____

Your current Dental health is: Good Fair Poor

Have you ever had a serious /Difficult problem associated with any dental work? YES NO

Do you floss daily? YES NO

Brush Daily? YES NO

Type of bristles on toothbrush? Hard Medium Soft

Have you ever had gum treatment? YES NO

Do your gums ever bleed? YES NO

Have you ever had periodontal disease? YES NO

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? YES NO

Are your teeth sensitive to heat, cold or anything else? _____

Do you have mobility in your teeth? YES NO

Do you still have wisdom teeth? YES NO

Would you like fresher breath? YES NO

Would you like whiter teeth? YES NO

Are you happy with your smile? YES NO

If no, what would you change? _____

For Women

Are you taking birth control pills? YES NO

Are you taking Hormones? YES NO

Are you pregnant? Week # _____ YES NO

Are you nursing? YES NO

Authorization and Release

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 in compliance with HIPPA and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____ Date _____