SARATOGA SMILE CARE
MARK MOREAU, FAGD

We warmly welcome you to our office. Please take a few moments to complete the following information so that we better care for you. It is our goal to help you reach and maintain maximum oral health.

Name ____
Prefer to be called: ________________________________
Home address: ______________________________________
Birth date: __________________ SSN#_________________
Hm. #_________________ Cell#_______________________
WK.___________________
Email____
How do you prefer to confirm your appointments?
(H)___ (W) ___ (C) ____

If student name of school / college
____
Marital status: S M D W CHILD
Responsible party for this account
Name:____
Address:____
Ph# (H) __________________ (C) _____________________
Employer:____
Other family members seen by us?
____
Whom may we thank for referring you
____?
In the event of an emergency, is there someone who lives near you that we should contact?
Name:____
Relation____
Hm. #_________________ Cell#________________
WK.___________________

DENTAL INSURANCE
Please provide dental insurance card if available
Insurance policy HOLDER: ___________________________
Address: ____
Birth date: __________________ SSN#_________________
Ph#:(h) _____________(C)_____________ (W)____________
Employer: ____
Employer address____________________________________
Insurance Co Name:__________________________________
Insurance Co address:________________________________
Group plan name_____________________________________
Group # (plan, local or policy#)________________
Insurance Co. phone: _________________________________
Subscriber ID#_______________________________________
SS# or assigned policy ID#
Subscriber Birth date: _________________________________
Payer ID#____
Patient relationship to insurance policy holder: ____________
If applicable (Individual) Patient ID #____________________

Dental Insurance Note: We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier. We agree to accept payment from any carrier that offers assignment of benefits. An estimate of your co-payment, deductible and charges not covered will be due at the time of services rendered.
Please familiarize with your specific plan as certain limitations may apply.

Release of information and assignment of Benefits:
I herby authorize Smile Sanctuary to apply for benefits on my behalf for covered dental services rendered. I request payment to be made to this office directly. I understand and agree that regardless of my insurance status, I am ultimately responsible for my account and any collection fees that are incurred if the balance is not paid in a timely fashion. I have agreed to the policies of Smile Sanctuary as stated above.

________________________ ________________________
Print Name Relationship to Patient

____
Signature Date

Medical History

Primary Care Physician Name ____________________________________

Are you currently under the care of another physician? Yes No

If yes, please explain____

Are you taking prescription/over the counter drugs or vitamins Yes No

If yes, please list ____

Do you smoke or use tobacco? Yes No

Please list any other serious medical condition(s) that you have ever had:

Do you take any blood thinners?(aspirin, coumadin, plavix…etc.) Yes No

Do you take any osteoporosis medication or biophosphonates? Yes No

For Women: Are you taking birth control pills? Yes No
Are you pregnant Yes No
Are you nursing Yes No

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

Y	N	Condition	Y	N	Condition
Y	N	Abnormal bleeding	Y	N	Hospitalized recently
Y	N	Alcohol/drug abuse	Y	N	Kidney problems
Y	N	Anemia	Y	N	Latex allergy
Y	N	Arthritis	Y	N	Liver disease / jaundice
Y	N	Artificial bones, joints, valves	Y	N	Low blood pressure
Y	N	Asthma	Y	N	Mitral valve prolapsed
Y	N	Blood Disease	Y	N	Nervous/Anxious
Y	N	Cancer/chemotherapy	Y	N	Osteoporosis
Y	N	Congenital heart defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric problems
Y	N	Dizziness / vertigo	Y	N	Radiation treatment
Y	N	Emphysema	Y	N	Respiratory problems
Y	N	Epilepsy	Y	N	Rheumatic /scarlet fever
Y	N	Fainting spells	Y	N	Seizures
Y	N	Frequent headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle cell disease
Y	N	Hay fever	Y	N	Sinus problems
Y	N	Head injury	Y	N	Stroke
Y	N	Heart disease	Y	N	Thyroid problems
Y	N	Heart murmur	Y	N	Tuberculosis
Y	N	Heart surgery	Y	N	Ulcers /reflux / gerd
Y	N	Hepatitis	Y	N	Venereal disease/std's
Y	N	Herpes/fever blisters	Y	N	
Y	N	High blood pressure	Y	N	
Y	N	HIV/AIDS			

Allergies

Are you allergic to any of the following items?

Y	N	Item	Y	N	Item
Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	other

Please list any other drugs you are allergic to:

____

Dental History

Reason for this visit:_____________________________________

Date of last dental visit:_____________

How would you describe the condition of your teeth and gums?

good fair poor

Are you currently in pain, discomfort or have sores with your teeth or gums? Yes No

If yes , please explain____________________________________

How often do you brush your teeth_________ Floss_________

Y	N	Question
Y	N	Do you have sensitive teeth?
Y	N	Do your gums bleed when you brush or floss?
Y	N	Do you have any sores / lumps in or near your mouth?
Y	N	Have you ever experienced difficulty in chewing
Y	N	Have you ever experienced pain in your jaw joint?
Y	N	Have you ever experienced any clicking in your jaw?
Y	N	Have you experience difficulty in opening or closing
Y	N	Have you ever been treated for TMJ symptoms?
Y	N	Do you grind or clench your teeth?
Y	N	Have you ever had orthodontic treatment
Y	N	Do you like your smile?
Y	N	

Please indicate if you are interested in learning more about the following dental services:

	Service
	Teeth straightening
	Implants
	Nutritional counseling
	Bonding
	Cosmetic veneers
	Teeth whitening

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence 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 service that I may need during diagnosis and treatment with my informed consent.

____
SIGNATURE DATE