Dentistry of Catawba
Daniel Smith, DMD
107 N. Main St
Catawba, NC 28609

Date_____ Home Phone_____Cell Phone _____

Full Name_____ Sex ____M____F Age_____ Date Of Birth_____

Address_____ City_____ State_____ Zip_____

Marital Status: Married_____ Widowed_____ Single____ Minor____ Separated____ Divorced____ Partnered____

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Work Phone_____

Primary Insurance

Who is responsible for this account?_____ Relationship to Patient?_____

Insurance Co. _____ Group#_____

Subscriber's Name: _____ Birthdate: _____

SSN: _____ Employer: _____

If the patient has additional insurance please notify someone at the front desk
****THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICYHOLDER ARE REQUIRED ****

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Smith all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature/Relationship:_____Date:_____

Dental History

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____Date of last dental x-rays_____

How often do you Brush?_____ How often do you Floss?_____

Health History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These Include Combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux(dexfenfluramine)
____Yes ____No

Have you ever taken any of the group of drugs collectively referred to as "bisphosphonates"? These include Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No

Do you have a history of bacterial endocarditis? ____Yes _____No *If yes, when were you diagnosed? _____

Place an (X) on "Yes" or "No" to indicate if you have or had any of the following:

AIDS/HIV ___Yes ___No
Anemia ___Yes ___No
Arthritis, Rheumatism ___Yes ___No
Artificial Heart Valves ___Yes ___No
Artificial Joints ___Yes ___No
Asthma ___Yes ___No
Bleeding abnormally with,
Extractions or surgery ___Yes ___No
Blood Disease ___Yes ___No
Cancer ___Yes ___No
Chemical dependency ___Yes ___No
Chemotherapy ___Yes ___No
Circulatory Problems ___Yes ___No
Congenital Heart Lesions ___Yes ___No
Cortisone Treatments ___Yes ___No
Cough, persistent/bloody ___Yes ___No
Diabetes ___Yes ___No
Emphysema ___Yes ___No
Epilepsy ___Yes ___No
Fainting/Dizziness ___Yes ___No
Glaucoma ___Yes ___No
Headaches ___Yes ___No
Heart Murmur ___Yes ___No
Heart Problems ____Yes ____No
Hepatitis _____Yes _____No
Herpes ___Yes ___No
High blood pressure ___Yes ___No
Jaundice ___Yes ___No
Kidney Disease ___Yes ___No
Liver Disease ___Yes ___No
Low Blood Pressure ___Yes ___No
Mitral Valve Prolapse___Yes ___No
Nervous Problems ___Yes ___No
Pacemaker ___Yes ___No
Psychiatric Care ___Yes ___No
Radiation Treatment ___Yes ___No
Rheumatic Fever ___Yes ___No
Scarlet Fever ___Yes ___No
Shortness or breath ___Yes ___No
Sinus trouble ___Yes ___No
Skin Rash ___Yes ___No
Special Diet ____Yes ____No
Stroke _____Yes ____No
Swollen Feet/Ankles ___Yes ___No
Swollen Neck Glands ___Yes ___No
Thyroid Problems ___Yes ___No
Tuberculosis ___Yes ___No
Tumor or growth on head or Neck ___Yes ___No
Ulcer ___Yes ___No
Weight Loss, unexplained ___Yes ___No

Do you wear contact lenses? ___Yes ___No

Women Only:
Are you pregnant? ___Yes ___No Due Date? _____ Nursing? ___Yes ___No Taking birth control? ___Yes ___No

Medications

_____

_____

_____

Allergies

Please mark (X) any of the following:

Aspirin ____
Barbiturates ____
Codeine ____
Latex ____
Local Anesthetic ____
Penicillin ____
Sulfa ____
Other (Please Specify): _____

Pharmacy Name _____ Phone: _____

Emergency Contact

Name _____Relationship_____Phone_____