

Sunny Smiles Family Dentistry Patient Information

Patient Name _____ Address _____

E-mail _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Sex _____ Social Security# (for insurance filings only) _____

Employer _____ Work Phone _____ Insurance Co _____

Policy or Group # _____

Guarantor/Spouse Full Name _____ Phone _____

Address if different from above _____

Employer _____ Insurance Co. _____ Work Phone _____

Policy or Group # _____ Employees's name _____

Employee's Social Security # _____ (if applicable for benefits) DOB _____

Preferred way to contact you: Home phone Work phone Cell E-mail

HEALTH QUESTIONS:

Is your general health good? _____ Physician Name and # _____

Do you use tobacco products? If so, are you interested in information on quitting? _____

Are you currently taking medications? _____ Blood thinners? _____

A medication list form is available on the next page. Any drug allergies? Please list _____

Please check any of these medical issues you have or ever had:

Heart disease Low blood pressure Joint Replacement Anxiety

Heart murmur High blood pressure Asthma HIV/AIDS

Diabetes Epilepsy Venereal disease Allergies

Ulcer Stroke Auto-immune disorder Tumor or other growth

Covid-19 Exposure to Covid-19 Cancer Kidney or liver disease

Sinusitis Shortness of breath on exertion Chest pain on mild exertion

Any other problem we should be aware of? _____

This information is strictly confidential and will not be released without permission. The guarantor for this account is responsible for payment in full.

Signature: _____ **Date** _____ **Patient, parent or guardian must sign prior to treatment.**