Strongsville Smile Keepers

Patient Information

NAME Last _____ First _____ MI ___ Preferred Name _____

M/F ____ Married ____ Single ____ Child ____

Date of Birth _____ SS#_____

Home Phone _____ Cell Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Email _____

Who referred you? ☐ Family member ☐ Friend ☐ Coworker Name:_____

Where have you seen us? ☐ Google ☐ Facebook ☐ Website ☐ Newspaper ☐ Movies Other:_____

Employer Name: _____ Employer Phone: _____

Responsible Party Information

NAME Last _____ First _____ MI ___

Relationship to Patient _____ Date of Birth _____ SS#_____

Home Phone _____ Cell Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Email _____

Employer Name _____ Address _____

City _____ State _____ Zip _____

Primary Insurance

Name of Insured _____ Date of Birth _____ SS# _____

Insurance Carrier _____ Subscriber ID _____

Group Plan _____ Group # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance

Name of Insured _____ Date of Birth _____ SS# _____

Insurance Carrier _____ Subscriber ID _____

Group Plan _____ Group # _____

Address _____ City _____ State _____ Zip _____

Medical History **Circle all that apply**

Acid Reflux/ GERD	ADHD/Autism	Alcoholism	Alzheimer's
Anemia	Anxiety Disorders	Arthritis	Artificial Joints
Asthma	BC/Hormone Therapy	Bisphosphonates	Blood Thinners
Cancer	Cerebral Palsy	Chemo/Radiation	Cholesterol
COPD	Diabetes	Epilepsy	Excessive Bleeding
Glaucoma	Hay Fever	Head Injuries	Heart Disease
Heart Murmur	Hepatitis	High Blood Pressure	HPV
Kidney Disease	Leukemia	Liver Disease	Low Blood Pressure
Macular Degeneration	Mental Disorders	Mitral Valve Prolapse	Multiple Sclerosis
Nervous Disorders	Osteoporosis	Pacemaker	Pregnancy
Premedicate	Radiation Treatment	Respiratory Problems	Rheumatic Fever
Seizures	Sinus Problems	Smoke	Snore/Sleep Disorder
STD	Stomach Problems	Stroke	Thyroid
Tuberculosis	Tumors	Ulcers	Vertigo

Other:_____

Surgery:_____

Do you need to be premedicated with antibiotics for dental procedures? NO / YES

Are you currently or have you ever taken medication for osteoporosis such as Actenol, Flosamax, or Boniva? NO / YES

Have you recently required medical assistance? NO / YES

Explain:_____

Current Medications: _____

Physician Name: _____ Phone Number: _____

Authorization and release

I have filled out this from to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care providers.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

X _____ Date _____

Signature of patient or parent if minor