CLASSIC SMILES
DENTISTRY

Welcome
to our practice

Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.
If you have any questions, please do not hesitate to call us.

Date: _____

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work / Home Phone: _____

E-mail: _____ Sex: Male / Female Marital Status: Single Married Other _____

Age: _____ Birthdate: _____ SSN: _____

Employer: _____ Phone: _____

Referred By: _____ Name of Person responsible for account: _____

In case of emergency who should we notify? _____ Relationship: _____

Cell Phone: _____ Home Phone: _____

INSURANCE INFORMATION - Policy Holder

Policy Holder's Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

SSN: _____ Birthdate: _____

Assignment / Release:

I, the undersigned, assign directly to Dr. D. Nwadike all 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 hereby authorize Dr. D. Nwadike to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I authorize Dr. D. Nwadike and dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Date: _____ Signature: _____

Minor / Child Consent:

I, being the parent or guardian of the patient listed above do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of local anesthetics or nitrous oxide ad deemed advisable by Dr. D. Nwadike, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____

Financial Policy:

I certify that I have read and understand the financial policy of Dr. D. Nwadike. I acknowledge that payment is due at the time of treatment, unless other arrangements have been made in advance. I understand that the parent/guardian is responsible for payment for services rendered for a child. I accept full responsibility for all charges not paid by my insurance.

Date: _____ Signature: _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former Dentist: _____ Date of last dental X-rays: _____

Address: _____

Check (✓) if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping Jaw
- ☐ Food collection between the teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken filing
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

PATIENT HEALTH HISTORY

This information is confidential and is only for use in your dental treatment, billing and processing of insurance claims. This information will not be shared with anyone without your permission.

Are you currently under the care of a physician? ☐ Yes ☐ No Physician's Name:_____

Date of last visit? _____If yes, for what conditions? _____

Are you taking any prescription or over the counter medications at this time? ☐ Yes ☐ No If yes, please list: _____

_____

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list: _____

Adverse reactions to any drugs? ☐ Yes ☐ No If yes, explain:_____

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.)

Check (✓) if you have had any of the following:

- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally with Extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis - Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Take Aspirin Regularly
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

Do you wear contact lenses? ☐ Yes ☐ No

WOMEN: Are you pregnant? ☐ Yes ☐ No Due Date:_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? _____

Please list anything else we should know about your medical history_____

_____

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my dental treatment and/or my overall health. I will not hold Dr. D. Nwadike or his staff responsible for the results of any errors or omissions made on this form.

*Date:*_____ *Signature:*_____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ if so,what _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ if so,what _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____