SuperSmiles
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Patient Name_____ **Preferred Name**_____
Contact Information:
Home Address: _____ City:_____ State:_____
Zip:_____ Home Phone: _____
Cell Phone: _____Email: _____
Emergency contact:
Name:_____Relationship:_____ Emergency Contact
Phone Numbers: _____

Have you had any changes to your Dental Insurance since your last visit? ____YES ____NO
If YES, please fill out the following:
Policy Holder Name: _____Policy Holder DOB:_____
Insurance Company Name:_____Employer Name:_____
Policy Holder ID#:_____Group Number_____

Medical History:
• Have you had any changes to your medical history in the past 6 months? _____**YES** _____**NO**
Please list any changes, surgeries, major illness or conditions:_____
• Are you currently taking any prescribed medications? _____**YES** _____**NO**. If Yes, please list **ALL** medications:
_____
_____
_____
• Have you taken or are you taking any prescribed pills that are to prevent or to treat bone loss from Osteoporosis or Osteopenia. If Yes, Please List:_____ Current_____or Past_____
• Have you ever received radiation treatment?_____ Current_____ or Past_____
• Are you currently taking any prescribed blood thinners?____YES _____NO.
If Yes, please list
• Are you allergic to any medications? _____YES _____NO
If Yes, Please List: _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient/Guardian Signature:_____**Date:**_____

Provider Signature:_____**Date:**_____