Smile Dental Associates, PC

333 South Oxford Valley Rd. Suite 501, Fairless Hills, PA 19030
Phone: (215) 949■2929

Patient Information Form

Patient Information

Full Name:	_____
Date of Birth:	____ / ____ / _____
Gender:	■ Male ■ Female ■ Other
Address:	_____
City/State/ZIP:	_____
Phone Number:	_____
Email:	_____

Insurance Information

Insurance Carrier:	_____
Policy Number:	_____
Group Number:	_____
Subscriber Name:	_____
Subscriber DOB:	____ / ____ / _____
Relationship to Patient:	_____

Medical History

Are you under the care of a physician now?	■ Yes ■ No
Any serious illness or operation?	■ Yes ■ No
Taking any medications (including herbal)?	■ Yes ■ No
Allergies to dental materials, latex, or meds?	■ Yes ■ No
Heart disease or cardiovascular issues?	■ Yes ■ No
Diabetes?	■ Yes ■ No
High blood pressure?	■ Yes ■ No
Asthma or breathing problems?	■ Yes ■ No

Other medical conditions:	_____

Emergency Contact

Name:	_____
Relationship:	_____
Phone Number:	_____

Consent & Acknowledgement

I certify that the above information is true and complete to the best of my knowledge. I authorize the dental office to release any information to process insurance claims. I understand that payment is due at time of treatment unless other arrangements have been made.

Signature: _____ Date: ____ / ____ / _____