Welcome to Smile Innovations Dentistry

Thank you for selecting our dental office! We strive to provide you with the possible dental care. To help us meet all of your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us!

Patient Information

Date_____

Name _____ Birthdate_____ Cell Phone _____

Address _____ City_____ State/Zip _____

Email _____ Home Phone_____ SSN _____

___ Minor ___ Single ___ Married ___Divorced ___ Widowed ___ Separated

Patient's Employer_____ Work Phone_____

Business Address_____ City _____ State/Zip _____

Spouse or Parent/Guardian's Name _____ Cell Phone _____

Person to Contact in Case of Emergency _____ Phone_____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account _____Relationship to Patient_____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ SSN _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? Y N Are there other family members? Y N

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State/Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Co. Address _____ City _____ State/Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Y N IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State/Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Co. Address _____ City _____ State/Zip _____

Whom May we thank for referring you? _____

Dental History

Reason for today's visit _____

Previous Dentist _____ Phone _____

Do you have, or have you had any of the following? Please Circle if YES

Burning Sensation of tongue	Blisters on lips or mouth	Bad breath
Sensitivity to cold/hot/sweets	Orthodontia (Braces)	Grinding/clenching
Sensitivity when chewing	Jaw pain/tiredness	Clicking of Jaw
Loose teeth/broken fillings	Lip or cheek biting	How often do you brush? _____
Sores or growths in mouth	Dry mouth	How often do you floss? _____
Mouth Breathing	Bleeding/swollen gums	