Please indicate if you had or have any of the following conditions by checking off boxes that apply:

☐ Heart problems	☐ Cancer	☐ Frequent urination
☐ Heart attack	☐ Chemotherapy	☐ Migraines/Severe headaches
☐ High Blood Pressure	☐ Surgery	☐ Emphysema/COPD
☐ Low Blood Pressure	☐ Radiation	☐ Sleep apnea
☐ Chest pain/Angina	☐ Acid reflux / GERD	☐ Snoring
☐ Stroke	☐ Ulcers	☐ CPAP
☐ Pacemaker	☐ Arthritis	☐ Grinding teeth
☐ Heart Valve Replacement	☐ Osteoporosis	☐ Clenching teeth
☐ Bleeding problems	☐ Fosamax/Actonel	☐ TMJ disorder
☐ Anemia	☐ Chronic pain	☐ Bronchitis
☐ Facial pain	☐ Fibromyalgia	☐ Asthma or Hay Fever
☐ HIV/AIDS	☐ Nervous/Mental problems	☐ Smoker:_____years
☐ Hepatitis	☐ Dementia	☐ Cigarettes/day: _____
☐ Artificial joints	☐ Alzheimer's Disease	☐ Cigars/week: _____
☐ Pre-Med for Dental Appt	☐ Tuberculosis	☐ Chewing tobacco _____ years
☐ Diabetes: Type 1 / Type 2	☐ Cosmetic surgery	☐ Quit/Never smoke anymore
☐ Kidney disease/Dialysis	☐ Botox	☐ Alcohol or drug abuse
☐ Thyroid disease	☐ Dermal fillers	Women Only:
☐ Epilepsy/Seizures	☐ Eye Problems/Glaucoma	☐ Oral contraceptive
☐ Dizzy/Fainting	☐ Contact dermatitis to costume jewelry	☐ Pregnant (currently)
☐ History of Anorexia/Bulimia	☐ Latex Allergy	☐ Nursing (currently)

If you marked yes to above questions, or if there is any condition not listed above, please explain_____
_____
_____

Do you have any allergies, particularly to medicines? _____Please list _____
_____
_____

Please describe any current or past medical treatment, including pending surgery, recent injuries, pregnancy or any other medical information we should be aware of:_____
_____
_____

Please list current prescription medication, including herbal, over-the-counter, supplements, birth control_____
_____

How long has it been since your last dental appointment?_____
Physician's name and number _____
If you could change your smile in any way, including whiter teeth, what would you want to change:
_____

Who may we thank for your referral to our office?_____

I understand the information on this form is essential to determine my dental and cosmetic needs and treatment. I acknowledge that all answers have been recorded completely and truthfully.

Patient Signature_____ Date_____

I give permission to Dr. Malcmacher to use my x-rays, pictures, and photographs in his lectures, seminars, publications, and other venues. I understand that my anonymity will be preserved.

Patient Signature _____Date_____

THE HEALTHY SMILE

PATIENT'S NAME_____Date_____
Date of Birth_____Social Security Number_____
Address_____City_____Zip_____
Home Phone_____Cell Phone_____
Email Address _____
Employer_____ Occupation_____
Work Phone_____ Okay to call work phone? Yes / No
Address_____City_____Zip_____

Emergency Contact _____Relationship _____
Emergency Contact Phone Number_____

SPOUSE'S NAME_____
Address_____City_____Zip_____
Home Phone_____Cell Phone_____
Occupation_____Work Phone_____
Employer_____
Address_____City_____Zip_____
Date of Birth_____Social Security Number_____

DENTAL INSURANCE (PRIMARY)_____
Address_____City_____State_____Zip_____
Customer Service Phone Number_____Group ID Number_____
Subscriber Name_____Dental ID Number_____

DENTAL INSURANCE (SECONDARY)_____
Address_____City_____State_____Zip_____
Customer Service Phone Number_____Group ID Number_____
Subscriber Name_____Dental ID Number_____

Charges incurred at The Healthy Smile for dental services, including insurance co-pays and deductibles, are due and payable at the time services are rendered. We do accept assignment of dental benefits. However, dental insurance is an agreement between you and your insurance company – you are ultimately responsible for payment of your bill regardless of the amount covered by your insurance. Accounts which are 60 days past due from the date of treatment will be charged a monthly fee of 1.75%. An additional processing fee of $250.00 will be charged if an account is turned over to a collection agency. There will be a charge of $30.00 for any returned non-sufficient funds check. My payments will be made by __Cash __Check __Credit Card__Care Credit.

I state that the above information is correct. I have read, understood, and agree with the above statements concerning payments and will comply with this policy.

_____ _____
Patient Signature Date