AFFORDABLE SMILES
1030 WASHINGTON AVE
EVANSVILLE, IN 47714-1844
812-437-4746

DATE_____

REGISTRATION

PATIENT'S NAME_____ _____SINGLE _____WIDOWED

DATE OF BIRTH_____ AGE_____ _____MARRIED _____DIVORCED

MEDICAID #_____ _____SEPARATED

NAME OF SPOUSE_____

IF A CHILD, PARENT'S NAME_____

IF PATIENT IS A MINOR WE NEED: *MOTHER'S BIRTH DATE*_____*FATHER'S BIRTH DATE*_____

STREET ADDRESS_____HOME PHONE_____

CITY_____STATE_____ZIP_____CELL PHONE_____

PATIENT'S E MPLOYER_____ HOW LONG_____WORK PHONE_____

SPOUSE'S EMPLOYER_____PHONE_____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PURPOSE OF THIS VISIT_____

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED_____PHONE_____

MEDICAL HISTORY (Please circle any of the following which apply)

AIDS	EPILEPSY	HIV	RHEUMATIC FEVER
ARTHRITIS	EXCESSIVE BLEEDING	JAUNDICE	RHEUMATISM
ARTIFICIAL JOINT	FAINTING	KIDNEY DISEASE	SINUS PROBLEMS
ASTHMA	GLAUCOMA	LIVER DISEASE	STOMACH PROBLEMS
BLOOD DISEASE	HEAD INJURY	MENTAL DISORDERS	STROKE
BLOOD THINNERS	HEART DISEASE	NERVOUS DISORDERS	THYROID DISEASE
CANCER	HEART MURMUR	PACEMAKER	TUBERCULOSIS
DIABETES	HEPATITIS	PREGNANCY	TUMORS
DIZZINESS	HIGH BLOOD PRESSURE	RADIATION TREATMENT	ULCERS
MITRAL VALVE PROLAPSE			

ALLERGIES TO: PENICILLIN, CODEINE, LATEX, ASPIRIN, ERYTHRO, SULFA, OTHER (list) _____

ARE YOU TAKING ANY MEDICATIONS (please list)

_____

_____

_____

NAME OF FAMILY DOCTOR_____PHONE_____

MAY WE REQUEST YOUR HEALTH RECORDS IF NECESSARY _____YES _____NO

DENTAL HISTORY

WHEN WAS YOUR LAST DENTAL VISIT? _____WHAT WAS IT FOR? _____

WHEN WAS YOUR LAST ORAL CANCER SCREENING? _____XRAYS? _____

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED?_____

NAME OF YOUR PREVIOUS DENTIST_____CITY_____ST_____

Please check any of the following problems that apply to you.

____Sensitivity (hot, colds, sweet)
Where? UR UL LR LL
____Headaches, earaches, neck pain
____Teeth or fillings breaking
____Grinding or clenching
____Bleeding swollen, or irritated gums
____Loose, chipped, or shifting teeth
____Bad breath

Do you have or have had any of the following?

____Dentures
____Partial dentures
____Braces
____Periodontal (gum) treatments

Do you smoke or use chewing tobacco? ___yes ___no How much? _____For how long? _____

Why did you leave your previous dentist?_____
_____
_____
_____

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CONSENT FOR DENTAL SERVICES

I hereby request and authorize the treating dentist and his/her auxiliaries to perform for me all dental treatment and surgery as indicated in my dental records and to do whatever procedures that are deemed advisable in his/her judgment. I also authorize the administration of anesthetics that may be deemed advisable by the doctor.

PATIENT'S
*SIGNATURE:*_____*DATE:*_____

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APPOINTMENT POLICY

Your appointment time is reserved just for you. If you are unable to keep your appointment, please let us know **24 hours** in advance so that we may schedule a new time for you.

We will attempt to reach patients by telephone at least two days before their scheduled appointment. It is crucial we have a current phone number in our records. If you do not have a telephone or we do not reach you, we ask that you contact us to confirm your scheduled appointment.

Please read and initial next to the following statements.

_____ **If we are unable to confirm your appointment at least 24 hours prior to the appointment date, YOUR APPOINTMENT WILL BE CANCELLED.**

_____ **If you fail to attend your confirmed appointment, you will NOT be rescheduled for future appointments and this information will be reported to the Indiana Health Coverage Program and you may risk losing your Medicaid benefits.**

I have read and fully understand the appointment policy of Affordable Smiles.

Patient's Signature: _____Date:_____