Seward Smiles
FAMILY DENTISTRY

137 North 7th Street Seward, NE 68434
402.643.3909 | info@sewardsmiles.com

PATIENT QUESTIONNAIRE

PERSONAL INFORMATION

Name _____

Preferred Name _____

Address _____

_____

Birthdate _____ ☐ Male ☐ Female

SSN _____

Phone# _____ (HOME) _____ (WORK)

Email _____

Employer _____

SPOUSE OR PARENT INFO

Name _____

Address _____

_____

Phone# _____

Employer _____

PRIMARY INSURANCE INFO

Dental Insurance Company Name

_____

Group/Plan # _____

Subscriber SSN/ID _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Employer _____

SECONDARY INSURANCE INFO

Dental Insurance Company Name

_____

Group/Plan # _____

Subscriber SSN/ID _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Employer _____

AUTHORIZATION

I hereby authorize the office to release all information necessary to secure the payment of benefits. I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of the signature on all my insurance submissions, whether manual or electronic.

Insurance is billed as a courtesy. I understand that I am responsible for payment of services rendered, including any co-payments and deductibles that my insurance does not cover. I understand that a service charge of 16% APR with a minimum of $0.50 will be added to all accounts over 60 days.

MAY WE DISCUSS DENTAL TREATMENT AND PAYMENT WITH YOUR SPOUSE? *(CIRCLE ONE)* **YES NO**

SIGNED X _____ _____

PATIENT SIGNATURE (PARENT MUST SIGN IF UNDER AGE 18) **DATE**

LIST PHYSICIAN

Physician's Name _____

Physician's Phone # _____

LIST MEDICATIONS

(include vitamins, herbs, diet pills, aspirin, nitro, chemo, insulin)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PREMEDICATION FOR DENTAL PROCEDURES

Check if you have had:

- ☐ Artificial Heart Valve
- ☐ Damaged Valves in Transplanted heart
- ☐ Previous Infective Endocarditis
- ☐ Congenital Heart Disease
- ☐ Joint Replacement (if so when) _____

Do you take antibiotics before dental procedures? Yes No

ALLERGIES (please check all that apply)

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Food Dyes
- ☐ Latex/Rubber
- ☐ Metals (jewelry, etc)
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

FOR WOMEN

Are you pregnant? ☐ Yes (*Date*) _____ ☐ No

Are you nursing? ☐ Yes (*Date*) _____ ☐ No

CONDITIONS (please check all that apply)

- ☐ Chronic Facial Pain
- ☐ Clenching/Grinding of Teeth (TMD)
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Frequent Urination
- ☐ Halitosis
- ☐ Head or Jaw Injury
- ☐ Hearing Problems
- ☐ Numbness
- ☐ Orthodontics
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Smoke
- ☐ Swollen Ankles
- ☐ Use Chewing Tobacco
- ☐ Use Controlled Substances
- ☐ Vision Problems

MEDICAL HISTORY (please check all that apply)

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Aphthous Ulcers (cold sores)
- ☐ ARC, HIV, Anti-HIV
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Back or Neck Injury
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Chemotherapy
- ☐ Congestive Heart Disease
- ☐ Diabetes Type I or II
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Fainting or Seizures
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heartburn
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes (fever blisters)
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Rheumatoid Arthritis
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Epilepsy
- ☐ Lupus
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Others Not Listed _____

The information given above is true and correct to the best of my knowledge. I understand that the information will be held in the strictest confidence; and it is my responsibility to inform the office of any changes in my medical status.

SIGNED X _____ _____

PATIENT SIGNATURE (PARENT MUST SIGN IF UNDER AGE 18) **DATE**

I acknowledge that this form has been updated:

Date:	Initial:	Date:	Initial:	Date:	Initial:	Date:	Initial:
Date:	Initial:	Date:	Initial:	Date:	Initial:	Date:	Initial: