LONDON BRIDGE SMILES **A Division of Atlantic Dental Care, P.L.C.**

Patient Information (please print)

Name_____ Social Sec. #_____ Date of Birth_____ Male/Female
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ E-mail_____

Employer_____ Occupation_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Marital Status_____ Spouse's Name_____ Spouse's Work Phone_____

How did you hear about our office?_____

Responsible Party (For MINORS)

Person responsible for this account_____ Relationship to Patient_____

Home Phone_____ Social Sec. #_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____ Work Phone_____

Dental Insurance Information

Policy Holder/Subscriber_____ Relationship to Patient_____

Subscriber ID#_____ Subscriber's Social Sec. #_____ Date of Birth_____

Insurance Co. Name & Phone #_____

Employer/Group Name_____ Group #_____

Do you have any additional dental coverage? If so, please complete the following.

Policy Holder/Subscriber_____ Relationship to Patient_____

Subscriber ID#_____ Subscriber's Social Sec. #_____ Date of Birth_____

Insurance Co. Name & Phone #_____

Employer/Group Name_____ Group #_____

Consent For Services

PLEASE READ AND INITIAL THE FOLLOWING

_____1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

_____2 Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ assistance as required to provide proper care.

_____3. I give permission to London Bridge Smiles to use my photographs for education and promotional purposes. I release my right for any compensation in connection with the use of these photographs.

Patient/Guardian Signature _____ Today's Date _____

LONDON BRIDGE SMILES **A DIVISION OF ATLANTIC DENTAL CARE, P.L.C.**

MEDICAL HISTORY

PATIENT NAME _____

Reason for today's visit_____ Date of last dental visit_____

Emergency Contact (not living with you)_____ Phone #_____

Physician's Name_____ Phone #_____

Are you currently taking any medications? Please List:

_____

Any Allergies? (Jewelry/Metals, Latex, Skin, Environmental, Medications) Please List:

_____

Do you have any of the following? (Check all that apply)

____AIDS/HIV Positive	____Diabetes- Type____	____Kidney Disease	____Scarlet Fever
____Anemia	____Eating Disorder	____Low Blood Pressure	____Seizures
____Arthritis	____Fainting	____Lung Disease	____Shortness of Breath
____Artificial Heart Valves	____Glaucoma- Type____	____Malignant Hyperthermia	____Sinus Trouble
____Asthma	____Hay Fever	____Migraines	____Stomach Problems
____Back/Neck Problems	____Heart Murmur/MVP	____Nervous Problems	____Swollen Ankles
____Blood Disease	____Hemophilia	____Pacemaker	____Thyroid Problem
____Blood Transfusion	____Hepatitis- Type____	____Prolonged Bleeding	____Tonsilitis
____Cancer	____Herpes	____Psychiatric Care	____Tuberculosis
____Canker Sores	____High Blood Pressure	____Radiation Treatment	____Venereal Disease
____Chemical Dependency	____TMJ/Jaw Pain	____Recent Weight Loss	____Joint Replacement

Do you smoke or uses any tobacco? Yes No

(OFFICE STAFF ONLY) Blood Pressure reading _____ Pulse _____

WOMEN

Are you pregnant? Yes No Planning on becoming pregnant in the next year? Yes No

If yes how many weeks? _____

Are you nursing? Yes No Are you taking Birth Control Pills? Yes No

Are you taking any medications for Osteoporosis or Osteopenia? Yes No Please List_____

Have you ever had eye surgery? YES NO

Type of surgery_____Date of surgery_____

Have you been admitted to a hospital or needed emergency care during the past two years? YES NO

If YES, please explain_____

To the best of my knowledge, all of the above information is true and correct. If ever there are any changes, I will inform London Bridge Smile at the next appointment without fail.

Patient's Signature_____ Date_____
(Or Parent/Guardian)