



# STEPHEN P. SMYTHE, DMD, PLLC FAMILY DENTAL CARE

SOUTHEND PROFESSIONAL OFFICE PARK  
5141 DIXIE HIGHWAY, SUITE 202 • LOUISVILLE, KY 40216 • (502) 448-2733

1. **Patient's Name** \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Last First Middle
2. Address \_\_\_\_\_  
Street City State Zip
3. Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_
4. E-Mail Address \_\_\_\_\_ Cell # \_\_\_\_\_ Work Phone \_\_\_\_\_
5. Whom may we thank for referring you? \_\_\_\_\_
6. Is another member of your family or relative a patient in our practice? \_\_\_\_\_

7. **Person Responsible for Payment** \_\_\_\_\_  
Last First Middle
8. Address \_\_\_\_\_  
Street City State Zip
9. Relationship to Patient \_\_\_\_\_
10. Social Security # \_\_\_\_\_
11. Birthdate \_\_\_\_\_ (If minor, list parents names:)
12. Driver's License # \_\_\_\_\_
13. Home Phone \_\_\_\_\_
14. Employer \_\_\_\_\_
15. Work Phone \_\_\_\_\_
- Father \_\_\_\_\_  
First Last
- Mother \_\_\_\_\_  
First Last

16. **Patient's Spouse Name** \_\_\_\_\_
17. Spouse's Employer \_\_\_\_\_
18. Occupation \_\_\_\_\_
19. Work Phone \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (need copy of card)

20. Insured's Name (employee) \_\_\_\_\_
21. Insured's Birthdate \_\_\_\_\_
22. Insured's Address (If different from above) \_\_\_\_\_
23. Insured's Social Security # \_\_\_\_\_
24. Insured's Employer \_\_\_\_\_
25. Insurance Co. Name \_\_\_\_\_ Group Name \_\_\_\_\_
26. Insurance Address \_\_\_\_\_

### EMERGENCY INFORMATION

27. Local Friend or Relative not living with you \_\_\_\_\_
28. Address \_\_\_\_\_
29. Phone No. \_\_\_\_\_

### GETTING TO KNOW YOU

30. What would you like for us to do for you today? \_\_\_\_\_
31. What are you looking for in a dental office? \_\_\_\_\_
32. Are you having dental problems at this time? .....YES / NO
33. Do your gums bleed at any time? .....YES / NO
34. Are you concerned about bad breath? .....YES / NO
35. Popping, clicking or pain in the jaw joint area? .....YES / NO
36. Do you feel very nervous about having dental treatment? .....YES / NO
37. Have you ever had a bad experience in the dental office? .....YES / NO
38. Why did you leave your last dentist? \_\_\_\_\_
39. Why did you select our office? \_\_\_\_\_
40. When was your last dental visit? \_\_\_\_\_
41. When was the last time you had complete dental X-rays taken? \_\_\_\_\_ Dentist? \_\_\_\_\_

## MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?..... YES  NO  
If yes, for what reason? \_\_\_\_\_
2. Please provide the name, address, and telephone number of your physician.  
\_\_\_\_\_
3. Have you been a patient in the hospital during the past two years? ..... YES  NO  
If yes, please list. \_\_\_\_\_
4. Have you ever had excessive bleeding requiring special treatment? ..... YES  NO
5. Have you ever been told by your doctor that you need to be premedicated prior to dental treatment? .... YES  NO
6. **Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?** ..... YES  NO  
\_\_\_\_\_
7. Of the following which you have had or have at present:

<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Allergic to Latex
<input type="checkbox"/> Angina Pectoris (chest pain)	<input type="checkbox"/> Hepatitis B (Serum)	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> X-Ray or Cobalt Treatment	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Chemotherapy (Cancer,Leukemia)	<input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea)
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> Stroke	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Hepatitis A (Infectious)	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Ulcers	<input type="checkbox"/> HIV Positive (AIDS)	<input type="checkbox"/> Sickle Cell Disease
8. List all medications you are taking at this time. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Are you a smoker? ..... YES  NO
10. Do you use or have you ever used recreational drugs? ..... YES  NO
11. When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired? ..... YES  NO
12. Do your ankles swell during the day? ..... YES  NO
13. Have you lost or gained more than 10 pounds in the last year? ..... YES  NO
14. Do you use more than 2 pillows to sleep? ..... YES  NO
15. Are you on a special diet? ..... YES  NO
16. Has your medical doctor ever said you have cancer or a tumor? ..... YES  NO
17. Do you have any disease, condition or problem not listed? If so, please list ..... YES  NO  
\_\_\_\_\_
18. Women: Are you pregnant:  YES  NO If yes, what month are you due? \_\_\_\_\_  
Are you taking birth control pills? ..... YES  NO

### FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE