Stephen P. Smythe, DMD, PLLC
Family Dental Care

Southend Professional Office Park
5141 Dixie Highway, Suite 101 • Louisville, KY 40216 • (502) 448-2733

1. Patient's Name _____ (Last / First / Middle) Driver's License # _____

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 _____

12. Driver's License # _____

13. Home Phone _____

14. Employer _____

15. Work Phone _____

(If minor, list parents names:)

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 a 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 if 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:

❑ Heart Failure	❑ Shortness of Breath	❑ Pain in Jaw Joints
❑ Heart Disease or Attack	❑ Emphysema	❑ Allergic to Latex
❑ Angina Pectoris (chest pain)	❑ Hepatitis B (Serum)	❑ High Blood Pressure
❑ Tuberculosis (TB)	❑ Liver Disease	❑ Heart Murmur/Mitral Valve Prolapse
❑ Asthma	❑ Allergies or Hives	❑ Bruise Easily
❑ Rheumatic Fever	❑ Diabetes	❑ Blood Transfusion
❑ Scarlet Fever	❑ Thyroid Disease	❑ Drug Addiction
❑ Artificial Heart Valve	❑ X-Ray or Cobalt Treatment	❑ Hemophilia
❑ Heart Pacemaker	❑ Chemotherapy (Cancer,Leukemia)	❑ Venereal Disease (Syphilis, Gonorrhea)
❑ Heart Surgery	❑ Arthritis	❑ Cold Sores or Fever Blisters
❑ Artificial Joint	❑ Rheumatism	❑ Epilepsy or Seizures
❑ Anemia	❑ Cortisone Medication	❑ Fainting or Dizzy Spells
❑ Stroke	❑ Glaucoma	❑ Nervousness
❑ Kidney Trouble	❑ Hepatitis A (Infectious)	❑ Psychiatric Treatment
❑ Ulcers	❑ HIV Positive (AIDS)	❑ 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 that 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