Smithtown
FAMILY DENTISTRY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*			**Gender:**		**DOB:**	
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
SS#:						
Address:						
Home #:		**Cell #:**		**Work #:**		
Employer:						
Employer's Address:						
Occupation:						
How did you hear about us?		**Email:**				

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	
Insurance Company Address:	
Plan ID#:	
Group#:	
Insured's Name:	**Relation:**
Insured's Birthdate:	**Insured's SS#:**
Insured's Employer	
SECONDARY DENTAL INSURANCE	
Insurance Company Address:	
Plan ID#:	
Group#:	
Insured's Name:	**Relation:**
Insured's Birthdate:	**Insured's SS#:**
Insured's Employer	

EMERGENCY CONTACT

Name:	**Relation:**
Best Contact #:	**Physician:**

DENTAL HISTORY

Previous Dentist:	**Last Dental Visit:**
Why have you come to the dentist today?	**Are you currently in pain?**
Have you ever required antibiotics before dental treatment?	
Are you happy with your smile?	
How can we alleviate any anxiety or make you feel more comfortable?	
Preferred pharmacy?	

MEDICAL HISTORY

Check if you have, or have had, any of the following. Please describe further details at the bottom if necessary:

☐ Artificial joints or heart valves	☐ History of heart attack, stroke	☐ Glaucoma
☐ Abnormal bleeding or blood thinners	☐ Heart surgery or pacemaker	☐ HIV+/AIDS
☐ High or Low Blood Pressure	☐ Seizures or fainting	☐ Kidney problems
☐ Heart problems, heart murmur	☐ History of emphysema, COPD	☐ Psychiatric treatment
☐ Diabetes	☐ Asthma	☐ Headaches or sinus problems
☐ Cancer, chemotherapy or radiation	☐ History of substance abuse	☐ Rheumatic/Scarlet Fever
☐ Shingles	☐ Sickle Cell Disease/Trait	☐ Tuberculosis
☐ Ulcers/Colitis	☐ Hepatitis	☐ Fever Blisters/Herpes
☐ Arthritis	☐ Anemia or blood transfusion	☐ Osteopenia/Osteoporosis
☐ Taken Fosamax or bisphosphonate drug	☐ Are you pregnant or nursing?	☐ Smoke, vape or use tobacco products?
☐ Tested positive for COVID-19 or antibodies	☐ COVID-19 vaccine?	
Other?		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Surgeries/Hospitalizations?

Year	Describe

Are you Allergic to the following?

Penicillin	No	Sulfa	No	Latex	No
Tetracycline	No	Aspirin	No	Dental Anesthetics	No
Erythromycin	No	Codeine	No	Jewelry/Metals	No

Please list any other drugs/materials you are allergic to and reaction:

I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that this information will be held in confidence. This information enables us to care for you in the most effective manner. Please inform the office of any changes in your medical status at each visit. I authorize the dental staff to perform any necessary dental services that I may require with my informed consent.

Signature: _____ Date: _____

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