

SHDS School House Dental Service
"We Style SMILES!" - Dr. Jerrold W. Smith, Sr., D. D. S.
DENTAL CARE APPLICATION

PLEASE PRINT

Single Married Widowed Divorced

Patient: Last name: _____ First name: _____

Social Security #: _____ Birth Date: _____ Driver's License: _____

Address: _____ Apt #: _____

City: _____ State/Postal Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Hours of Work: _____

Employer Address: _____ City/State/Zip: _____

Insurance Co.: _____ Policy No.: _____

Physician: _____ Physician Phone: _____

Physician Address: _____ City/State/Zip: _____

Single Married Widowed Divorced

Spouse/Parent: Last name: _____ First name: _____

Social Security #: _____ Birth Date: _____ Driver's License: _____

Address: _____ Apt #: _____

City: _____ State/Postal Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Hours of Work: _____

Employer Address: _____ City/State/Zip: _____

Alternate contact who will accept messages: _____ Phone: _____

NAMES OF CHILD/REN	Boy/Girl	BIRTHDATE (MM/DD/YY)	NAME OF SCHOOL	GRADE
_____	B_ G_	_____	_____	_____
_____	B_ G_	_____	_____	_____
_____	B_ G_	_____	_____	_____
_____	B_ G_	_____	_____	_____

Special Notes: _____

Patient Health Information

Previous Dentist: _____ Last Dental Date: _____

Reason For Last Visit: _____

Please Check Those That Apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | OTHER: _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | Due date: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | _____ |

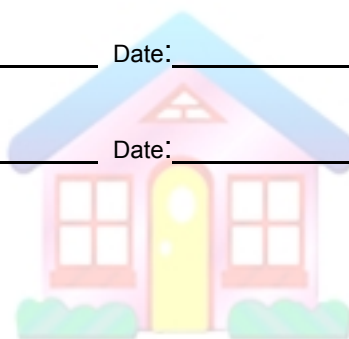
Consent For Services

Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible



D | E | N | T | A | L