Springfield Healthy Smile
Healthier and Brighter Smile You Deserve

Patient Registration

First Name:	M:	Last Name:	Sex: M F
Date of Birth: / /		SSN:	
Mailing Address: Street:			
City:		State and Zip:	
Primary contact number		( )	
Additional contact number		( )	
Martial status:		Email address:	
Time preference to contact you		am:	pm:
Parent's Name (if patient a minor):		Phone: ( )	

Additional Patients (Spouse or children under the same insurance)

First Name:	M:	Last Name:	Sex: M F
Date of Birth: / /		SSN:	
Contact number (if different form above)		( )	

First Name:	M:	Last Name:	Sex: M F
Date of Birth: / /		SSN:	
Contact number (if different form above)		( )	

Dental Insurance Information

Insurance Company:		ID:	
Subscriber Information:	First Name:	Last Name:	Sex: M F
	Date of Birth: / /	SSN:	
Subscriber Employer:			
Subscriber relationship to patient:			

Patient/Parent/Subscriber Authorization Statement:

I hereby authorize Springfield Healthy Smile P.C. and Dr. Maryam Saba (provider) to provide dental services to me and my dependants and children and apply for benefits on my behalf for covered services rendered. I request that the payments from my insurance company be made to the above named corporation and/or provider(s). I certify that the information that I have provided above is correct and further authorize the release of any necessary information including medical, dental and insurance coverage information to my insurance company in order to determine my insurance benefits to which I may be entitled. I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as the original, this authorization may be revoked at any time in writing. I understand and agree that (regardless of my dental insurance status or coverage), I am **ultimately** responsible for the balance on my account and my dependents for any dental services rendered. **If my account becomes past due I agree to pay all costs of collections and litigations if any.** I have read this entire sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge and I will notify Springfield Healthy Smile P.C. of any changes in my status or the above information.

Patient Signature:	Date:
Parent Signature (if patient a minor)	

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Patient Medical History	Date completed/Updated:
Patient Name:	Sex: M F
Date of Birth: / /	
Primary Physician:	
Name	Office number:
Additional Physician Information	
Name	Office number:

Medical History						
			Yes	No	Please Specify:	
Are you under any medical treatments now?						
Have you been hospitalized for any surgical operation or serious illness?						
Are you taking any prescription and non prescription medications including herbal and over the counters medications?						
Do you use tobacco?						
Do you use alcohol?						
Do you use any illegal substances?						
Do you bleed easily?						
Are you allergic to any medication?						
Are you allergic to any substance such as Latex, etc.						
Have you had any allergic reaction to the following:						
Local Anesthetics	Barbiturates	Aspirin	Penicillin or other antibiotics (please specify)			
Sedatives	iodine	Sulfa drugs	Other:			
Women Only:					Yes	No
	Are you pregnant or think you may be pregnant?					
	Are you nursing?					
	Are you taking birth control pills?					
	Are you taking any hormonal replacement therapies?					
Do you have or had any of the following:						
	Yes	No		Yes	No	
High Blood pressure			Frequently tired			
Heart attack			Anemia			
Stomach troubles/ulcers/bleeding			Sexually transmitted disease			
Fainting seizures			Cancer			
Asthma			Cardiac pacemaker			
Low blood pressure			Kidney disease			
Epilepsy/convulsions			Heart murmur			
Rheumatic fever			Joint replacement or implant			
Rheumatic arthritis			Chest pain			
Respiratory problems			Glaucoma			
Hay fever			Radiation therapy			
Tuberculosis			Recent weight loss			
Trouble sleeping			Thyroid problems			
Other (please specify):						

Patient Dental History				Yes	No
Do you gums bleed when brushing or flossing?					
Are you heat sensitive to hot or cold liquids or foods?					
Are you teeth sensitive to sweet or sour liquids or foods?					
Do you feel pain to any of your teeth?					
Do you have any sore or lumps in or near your mouth?					
Have you had any neck or jaw injuries?					
Do you have frequent headache?					
Do you clench or grind your teeth?					
Have you ever had instructions on the care of your gums?					
Do you bite your lips or cheeks frequently?					
Have you had any orthodontic work?					
Have you ever had instructions on the correct method of brushing your teeth					
Have you ever experienced any of the following problems jaw or mouth:					
	Yes	No		Yes	No
Clicking			Difficulty in chewing		
Pain in joint, ear side or face			Difficulty opening or closing mouth		
Other (please specify):					

I certify that I have read and understood the above information. I have correctly answered to the above information to the best of my knowledge for myself or for the patient named below (if patient a minor).

I understand that providing incorrect information can be dangerous to my health or the patient named below (if patient a minor). I will also notify Springfield Healthy Smile P.C. and Dr. Maryam Saba (or other providers), should any of above listed medical or dental information change.

Patient Signature:	Date:
Parent Signature (if patient a minor)	