

# Smithsburg Family Dentistry

**Thomas M. Nussear, DDS**

*Comprehensive Dentistry*

40 South Main Street • Smithsburg, MD 21783

301-824-2080

## WELCOME!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

Date: \_\_\_\_\_

Check Appropriate Box:     Minor     Single     Married     Divorced     Widowed     Separated

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Email address \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Patient's Employer/School \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's (if minor)/Spouse's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient's/Spouse's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's License No. \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our Office?     Yes     No

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Carrier ID \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Maximum Annual Benefit \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?**     Yes     No    **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Carrier ID \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Maximum Annual Benefit \_\_\_\_\_

PATIENT INFORMATION  
EMPLOYMENT/SCHOOL  
RESPONSIBLE PARTY  
INSURANCE INFORMATION



### MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you

- Pregnant/Trying to get pregnant?  Yes  No
- Taking oral contraceptives?  Yes  No
- Nursing?  Yes  No

Are you taking any medications, pills or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

### DENTAL HISTORY

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/food? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic work?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding		
Have you ever experienced any of the following			following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
problems in your jaw?			Have you ever had instruction on the correct		
Clicking? .....	<input type="checkbox"/>	<input type="checkbox"/>	method of brushing your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had instruction on the care		
Difficulty in opening or closing? .....	<input type="checkbox"/>	<input type="checkbox"/>	of your gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had cold sores in the past frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.