

Smile Today Dental

designer smiles for active lifestyles



Evelyn Kidonakis, DDS

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

SS # _____

Today's Date _____

Email Address _____

Patient Information

Name _____ Nick Name _____

Birthdate _____ Home Phone (____) _____ Work (____) _____ Cellphone (____) _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Spouse or Parent's Name _____ Work Phone (____) _____

If Patient is a Student, Name of School/College _____ City _____ State _____

How Did You Hear About our Practice? _____

Hobbies/Interests _____

Person to Contact in Case of Emergency _____ Phone (____) _____

Responsible Party

Name of Person Responsible for this Account _____

Relation to Patient _____ Cell Phone (____) _____

Address _____ Home Phone (____) _____

Driver's License No. _____ Birthdate _____

Employer _____ Work Phone (____) _____

Employer's Address _____ City _____ State _____ Zip _____

Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security No. _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Additional Insurance

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security No. _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

Health Questions

Name: _____ Date: _____

Is your general health Excellent Good Fair Poor

Do you have any allergies to any foods, medications, metals, powder, latex or earrings? YES NO
If so, which ones? _____

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

YES NO Heart trouble?

If yes, please explain _____

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO High blood pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO Bleeding Problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Postural hypotension (fainting spells) | <input type="checkbox"/> YES <input type="checkbox"/> NO Blood diseases |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO Hemophilia (clotting) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Mitral valve prolapse | <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Infective endocarditis | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Pacemaker / defibrillator | <input type="checkbox"/> YES <input type="checkbox"/> NO Hormonal problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Artificial(prosthetic)heart valve or valves | <input type="checkbox"/> YES <input type="checkbox"/> NO Thyroid problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO Epilepsy or seizures |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Chest pains | <input type="checkbox"/> YES <input type="checkbox"/> NO Bone diseases |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Lung disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Antidepressant medications |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO Immunosuppression |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Cancer/Leukemia | <input type="checkbox"/> YES <input type="checkbox"/> NO HIV or AIDS |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Radiation therapy to the head and neck | <input type="checkbox"/> YES <input type="checkbox"/> NO Liver disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Chemotherapy | <input type="checkbox"/> YES <input type="checkbox"/> NO Arthritis |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Artificial (prosthetic) joints | <input type="checkbox"/> YES <input type="checkbox"/> NO Sinus problems |

If yes, when was the artificial joint placed _____

- YES NO Infected artificial joint
- YES NO Systemic lupus erythematosus chronic autoimmune disease
- YES NO Females: are you pregnant or nursing
- YES NO Females: are you taking birth control pills
- YES NO Are you taking blood thinners(including aspirin)

Is there any other information about your health which should be known? YES NO

If so, what? _____

Please list *all* current medications _____

Are you under the care of a physician now? YES NO

Being treated for _____

Physician name _____

Physician address and telephone (if known) _____

Updates (to be completed at later visits)

Date _____ Signature _____

(patient or parent if minor)

Date _____ Signature _____

(patient or parent if minor)

Date _____ Signature _____

(patient or parent if minor)

Dental History

Name: _____

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____ Date of last dental X-rays _____

Check (✓) if you have had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Food collection between the teeth |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growth in your mouth |
| <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Gums swollen | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Burning sensation on tongue |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Jaw pain or tenderness | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Pain around the ear | <input type="checkbox"/> Fingernail biting | <input type="checkbox"/> Chew on one side of mouth |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Mouth pain, brushing | <input type="checkbox"/> Foreign objects |

How often do you floss? _____ How often do you brush? _____

Do you like your smile? Yes No _____

Are you happy with the shape of your teeth? Yes No _____

Are you happy with the color of your teeth? Yes No _____

Is there anything you would like to change about your teeth? Yes No

If yes, please describe _____

I understand that, as a service to me, Dr. Kidonakis will assist me in processing my insurance claims. However, I am responsible for all fees in their entirety.

_____ Date: _____

Signed (patient or parent if minor)

I authorize the use of my radiographs and/or photographs for use in seminars or publications of Dr. Kidonakis.

_____ Date: _____

Signed (patient or parent if minor)

ONLY IF YOU HAVE INSURANCE : SIGNATURE ON FILE

So you don't have to sign an insurance form at each dental visit, Dr. Kidonakis will maintain this "signature on file" for you.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatments, or benefits payable for this claim of the Plan Administrator agent for the purpose of determining benefits payable.

_____ Date: _____

Signed (patient or parent if minor)

AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment directly to Evelyn Kidonakis, D.D.S. Ltd. for services rendered.

_____ Date: _____

Signed (subscriber or patient if minor)

**THE HIGHEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF THEIR FRIENDS AND FAMILY.
THANK YOU FOR YOUR TRUST.**

THANK YOU FOR CHOOSING US FOR YOUR DENTAL CARE