Irmo SMILES

Welcome to Irmo Smiles!

We are delighted that you have chosen our office to evaluate your dental needs. We strive to provide the most thorough dental service in the most caring and relaxed atmosphere available. Your addition to our family of happy and satisfied patients is most welcomed.

As a new patient, your initial appointment will consist of a thorough oral evaluation that will include a comprehensive examination to check for oral cancer, gum disease, bite problems, jaw joint problems, cavities and broken or damaged teeth along with a dental prophylaxis (cleaning). Your doctor will evaluate any existing dentistry or dental appliances you currently have and talk with you about concerns you may have regarding the appearance of your smile. Your examination will include all x-rays and tests necessary to perform a complete diagnosis. The findings of the examination will be discussed in full detail and specific recommendations will be made.

Enclosed you will find confidential patient information forms for you to complete. We recognize that your time is important. Except in emergency situations, you can expect us to be on time for you.

We look forward to helping you look and feel your best through good oral health.

Sincerely,

Appointment Coordinator
Irmo Smiles

Irmo SMILES

Dental
Adult Medical History

Medical History

Do you now, or have you ever had any of the following? (Please check all that apply.)

- ○ AIDS/HIV
- ○ Allergies
- ○ Anemia
- ○ Anesthesia Allergy
- ○ Arthritis
- ○ Artificial Joints
- ○ Asthma
- ○ Beta Blocker
- ○ Blood Disease
- ○ Blood Thinners
- ○ Cancer
- ○ Cephalosporin Allergy
- ○ Codeine Allergy
- ○ Diabetes
- ○ EES
- ○ Epilepsy
- ○ Erythromycin Allergy
- ○ Excessive Bleeding
- ○ Fainting
- ○ Glaucoma
- ○ Growths
- ○ Hay Fever
- ○ Head Injuries
- ○ Heart Disease
- ○ Heart Murmur
- ○ Hepatitis ○ A ○ B ○ C
- ○ High Blood Pressure
- ○ Kidney Disease
- ○ Latex Allergy
- ○ Liver Disease
- ○ Mental Disorders
- ○ Mitral Valve Prolapse
- ○ Motrin Allergy
- ○ Nervous Disorders
- ○ Pacemaker
- ○ Penicillin Allergy
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Sinus Problems
- ○ Stroke
- ○ Sulfa Allergy
- ○ Tetracycline Allergy
- ○ Tuberculosis
- ○ Tumors
- ○ Ulcers
- ○ Venereal Disease
- ○ Other _____

Dental History

Date of last dental visit _____ Reason for visit _____

Have you ever had complications following a dental treatment? ○ Yes ○ No
If yes, please explain. _____

Have you been admitted to a hospital or received emergency care during the past two years? ○ Yes ○ No
If yes, please explain. _____

Name of physician _____ Phone _____

Please list all medications you are currently taking. _____

Do you have health problems that need further clarification? ○ Yes ○ No
If yes, please explain. _____

Women Only:
Are you pregnant or think you may be pregnant? ○ Yes ○ No
Are you nursing? ○ Yes ○ No
Are you taking birth control pills? ○ Yes ○ No

Patient Signature/Legal Guardian for Minors _____ Date _____

Irmo SMILES

Dental
Adult Patient Information

Patient Information

Today's Date _____

Your Name

Last _____ First _____ Middle _____ ○ Mr. ○ Mrs. ○ Miss

Date of Birth _____ Age _____ SSN _____ Marital Status _____

Emergency Contact _____ **Phone #** _____

Mailing Address

Street _____ Apt. # _____

City _____ State _____ Zip _____

Email _____ Cell Phone _____ Home Phone _____

Employer _____ Job Title _____ Work Phone _____

How did you hear about our office?

○ Family ○ Friend ○ Close to home/work ○ Other _____

Responsible Party

This person is responsible for payment if patient is minor/under the age of 18.

Your Name _____ ○ Mr. ○ Mrs. ○ Miss

Relationship to patient _____ Date of Birth _____ SSN _____

Mailing Address _____

Email _____ Cell Phone _____ Home Phone _____

Employer _____ Job Title _____ Work Phone _____

Insurance Information

You may skip this section if we have received your insurance information prior to appointment.

Subscriber's Name _____ DOB _____ SSN _____

Subscriber's Address (if different from above) _____

Subscriber's Phone (cell) _____ Alternate Phone _____

Subscriber's Employer _____ Occupation _____

Insurance Company _____ Phone _____

Group # _____ ID# _____

General Consent for Treatment

I understand that the purpose of this form is to obtain consent for dental treatment. In general terms, treatment is: dental restorations, sealants, extractions, exams, cleanings, local anesthetic, and nitrous oxide. I understand that every dental patient has the right to informed consent and other consent may be provided for more specific treatment. That means that as a patient, or as a legal guardian for a patient, I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment.

DENTAL TREATMENT

I understand that complications may occur during or after treatment and that no dental treatment is completely risk free, as the practice of dentistry is not an exact science. A partial listing of the risks known to be associated with dental treatment are:

Infections, bleeding, bruising, paresthesia or numbness of tongue, mouth or face, instrument breakage, swallowing or aspiration of objects, allergic reactions to drugs, jaw pain or difficulty opening mouth, temporary soreness, temperature sensitivity, bacterial endocarditis, additional oral surgery, hospitalization, or further treatment upon complications.

ANESTHETIC

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

ACKNOWLEDGMENT

I have read and understand the information stated above. I have the right to ask for more information if I have any concerns, and I will use that right to its fullest extent. I understand the success of this treatment and the avoidance of treatment complications depends upon my complying with the instructions, restrictions, and any recommendations, that have been explained to me. I also understand that I am to notify the dentist immediately of any suspected complications, where further treatment may be discussed or administered, which is not currently anticipated.

Signature: _____ Date: _____

Relationship to Patient: _____