Welcome to the office of Smiley Doctor (Dr Reena Gupta)

373 South Monroe, Suite 203 San Jose CA 95128

We Always deliver the highest quality dental care in a friendly and relaxed environment

Today's Date _______________

Patient Information

Patient Name ________________________ Date of birth ____________

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Home Address ________________________ City __________ Zip ________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Social Security # ________________ Driver's License # ________________

Name of Nearest Relative (Not living with you) ________________________

Relationship ________________ Relative's Phone Number ____________

Who should we thank for referring you? (or mention referral source) ________________

Responsible Party (if patient is a minor) ________________________

Student? ☐ Full Time ☐ Part Time ☐ School ____________ Location ____________

Insurance Information

Name of the Insured ________________________ Date of birth ____________

Billing Address ________________________ City ________ State_____ Zip ________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Social Security # ________________ Driver's License # ________________

Employer ________________________ Employment Start Date ____________

Employer Address ________________________ City ________ State ____ Zip ________

Insurance Company ________________________ Group # ____________ Local # ________

Insurance Co Address ________________________ City ________ State ____ Zip ________

Insurance Coverage (check all that apply) Self ☐ Spouse ☐ Children ☐ Other(s) ____________

Relationship if "Others" is checked above ________________________

Consent: The undersigned hereby authorizes the doctor or qualified personnel to take radiographs (X-Rays), study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis for the purpose of dental treatment and care. I also authorize the doctor to perform any and all treatments and therapy and prescribe medications that may be needed for dental care for the patient named above. I further authorize and consent that the doctor may choose and employ such assistance as he/she deems fit. I also understand that the anesthetic agents embodies a certain risk. I understand that the responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless an extended payment plan is arranged with the business office. I understand that a credit check will be done, if I elect not to pay at the time service is rendered.

Insurance note: The office is happy to work with the patients for paperwork regarding dental insurance claims. We ask you to read your dental insurance policy to be sure that you are fully aware of any limitations of the benefits provided. The fees we charge to those who are insured are our usual and customary fees. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the benefits coverage of procedure types and fees. We cannot render services on the assumption that the charges will be paid by the insurance company. We ask that you look upon your insurance realistically as a method which reimburses you for dental expenses partially or fully depending on the treatment received in this office. We will be pleased to complete all forms pertaining to your claim, and send them promptly to your insurance carrier, to help you obtain the reimbursement you are entitled to receive.

Signature ________________________ Date __________ Relationship to patient ____________

Health Questionnaire

In order for any doctor to thoroughly diagnose any condition, we must have accurate data so that we may give personal attention to each individual. This information is confidential. Thank You.

Dental History

Reason for Today's visit ____ Date of last Dental Care _______________
Former Dentist ____ Date of last Dental X-Rays _____________
Former Dentist Address _________________________________ City _____________State ______ Zip ___________
Former Dentist Phone Number ____________________ How long since you last visited a dentist? _________________
How often do you brush? _________________________How often do you floss? ______________________________
Have you ever had a local anesthetic (Novocaine, etc)? Yes☐ No☐
Have you ever had adverse reaction to a local anesthetic? Yes ☐ No ☐
Have you had any serious trouble associated with previous dental treatment? Yes ☐ No ☐
If Yes, What? ____
Do you use tobacco? Yes ☐ No☐ If Yes, What Type? Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing ☐
Does dental treatment make you nervous? No ☐ slightly ☐ Moderately ☐ Extremely ☐
Check all that apply:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding Teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

Medical History

Physician's Name ______________________________________ Phone# _________________________
Physician's Address ____________________________________ City _________________ Zip __________
Are you in good health? Yes ☐ No ☐
Date of last physical examination? _________________ Any Current treatments?_______________________
Have you ever had a serious illness or operation? Yes☐ No ☐ If yes, what? _________________________
Have you been hospitalized in the last 5 years? If Yes, why? ____
Are you taking any drug or medicine? Yes☐ No ☐ If yes, What? __________________Dosage___________
Are you sensitive or allergic to any drug? Yes☐ No ☐ If yes, which ones? __________________________
Have you ever had a blood transfusion? Yes☐ No☐ If, yes, give approximate dates? ___________________
Have you ever taken any group of drugs referred to as “fen-phen”? These include combinations of Lonimin, Adipex, Fastin (Phentermine brands), Pondimin (fenfluramine) and Redux (defenfluramine). Yes☐ No ☐
Women, are you pregnant? Yes☐ No ☐ Nursing? Yes☐ No ☐ Taking birth control pills? Yes☐ No ☐
Warning: Antibiotics may alter the effectiveness of birth control pills

Check if you have or had any of the following? Check all that apply:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV / AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Sinus Trouble
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet Area
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Veneral Disease

Do you have any disease, condition or problems not listed? If yes, describe ___________________________________

Signature

To the best of my knowledge, the information is complete and correct. I understand that it is my responsibility to inform my doctor, if or my minor child, ever have a **change in health**

____ ______________________
Signature of Patient, Guardian or Personal Representative Date

____ ______________________
Please Print name the Signature of Patient, Guardian or Personal Representative Relationship to Patient