# Welcome to Smile Lee Family Dentistry

**8351 Standonshire Way Ste. 121 Raleigh, NC 27615**

**We are pleased to have you as a patient in our practice. Please take a few moments to fill out this from as completely as you can.**

## PATIENT INFORMATION

| | | |
|---|---|---|
| ☐ Mr.<br>☐ Mrs.<br>☐ Ms. | Patient's Legal Name : (Last) (First) (Middle) | 한글성명 (Optional) : |

| | | | |
|---|---|---|---|
| Marital Status :<br>☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of Birth (MM/DD/YYYY) :<br>/ / | Age: | Sex:<br>☐ M ☐ F |
| Street Address : | Home Phone Number :<br>( ) - | Cell Phone Number :<br>( ) - | |

| | | | | |
|---|---|---|---|---|
| City : | State : | ZIP Code : | Social Security Number :<br>- - | ※ Your social security number will be used for insurance verification and patient identification purposes only. |

What is your preferred method of contact?

☐ Call cell phone ☐ Text cell phone ☐ Call home phone ☐ Call work phone ☐ E-mail ☐ Mail ☐ Other: _____

How did you find us? (Please check one box):

☐ Referred by Dr. _____ ☐ Family ☐ Friend ☐ Newspaper ☐ Web Search ☐ Other : _____

Email :

## DENTAL INSURANCE INFORMATION

Please give your insurance card and a valid photo I.D. to the receptionist.

Do you have dental insurance? ☐ No ☐ Yes (Please check or specify your primary insurance below)

☐ Aetna ☐ Ameritas ☐ Blue Cross Blue Shield of NC ☐ Careington CP-50 ☐ Careington Care POS ☐ Cigna DPPO

☐ Cigna Advantage ☐ Delta Dental Premier ☐ Dental Network of America ☐ Guardian ☐ HealthSmart

☐ Humana ☐ Medicaid / Medicare ☐ Metlife ☐ Sun Life ☐ United HealthCare ☐ Other : _____

| | | | |
|---|---|---|---|
| Policy Holder's Name : | Date of Birth (MM/DD/YYYY) :<br>/ / | Policy Holder's S.S.N. :<br>- - | ※ Your social security number will be used for insurance verification and patient identification purposes only. |

| | | |
|---|---|---|
| Employer : | Policy Group Number : | Policy Number : |

Relationship to Policy Holder : ☐ Self ☐ Spouse ☐ Child ☐ Other : _____

## IN CASE OF EMERGENCY

| | | |
|---|---|---|
| Name of local friend or relative | Relationship to the patient : | Phone Number :<br>( ) - |

## HEALTH INFORMATION

**Your health information will be kept confidential and will be used so we may serve you better.**

**Do you Smoke ?** ☐ **Yes. How often/many :** _____ ☐ **No.**

**Last Dental visit :**

**What is the primary reason for your visit today?**

☐ **Check-up** ☐ **Cleaning** ☐ **Pain** ☐ **Cavities** ☐ **Other (Please explain) :** _____

**Do you have any allergies?**

☐ **I do not have any allergies.**

☐ **Aspirin** ☐ **Penicillin** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Sulfa Drugs** ☐ **Other (Please specify) :** _____

**Have you had any hip or knee replacement surgeries?**

☐ **No** ☐ **Yes (If yes, please specify:**_____**)**

**Please mark all of the conditions you have are receiving treatment for :**

| | | | |
|---|---|---|---|
| ☐ **AIDS / HIV** | ☐ **Asthma** | ☐ **Anemia** | ☐ **Arthritis** |
| ☐ **Blood Pressure Conditions (Please specify:** ☐ **High** ☐ **Low)** | | ☐ **Cancer** | ☐ **Chest Pain** |
| ☐ **Depression** | ☐ **Diabetes** | ☐ **Fibromyalgia** | ☐ **High Cholesterol** |
| ☐ **Heart Disease** | ☐ **Hepatitis A** | ☐ **Hepatitis B or C** | ☐ **Kidney Problems** |
| ☐ **Liver Disease** | ☐ **Osteoporosis** | ☐ **Stroke** | ☐ **Thyroid Disease** |
| ☐ **Tuberculosis** | ☐ **Other:** | ☐ **None** | |

**Are you currently taking any prescribed or over-the-counter medications ( No Vitamins ) ?**

☐ **Yes (Please specify all medications and dosage below)** ☐ **No**

1. _____
2. _____
3. _____
4. _____
5. _____

**FOR WOMEN : Are you currently: Yes or No**

☐ **Pregnant or trying to get pregnant** ☐ **Nursing** ☐ **Taking oral contraceptives**

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

_____

***Patient or Guardian Name (Print)***

_____ _____

***Patient or Guardian Signature*** ***Date***