

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Male Female Married Single Child Other: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____
 E-Mail Address: _____
 Address: _____
Street Apartment #

City State Zip Code
 Closest Relative _____ Phone Number _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Cardiac |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Congenital Heart Valve Disease | <input type="checkbox"/> Cardiac Transplant |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bacterial Endocarditis | (Excluding MVP) | Valvulitis? _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | Please Specify: _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> List Medications _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaundice | | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Sulfa Allergy | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prosthetic Cardiac Valve | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Drug/ Alcohol Abuse | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke | UPDATE _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis | UPDATE _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Tumors | UPDATE _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Ulcers | UPDATE _____ |
| <input type="checkbox"/> Glaucoma | Due date: _____ | | UPDATE _____ |
| <input type="checkbox"/> Growths | | | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

* _____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend / relative Name: _____
 Dental Office Yellow Pages Newspaper School Work Other: _____

Smiles by Design

Employment Information

The following is for: the patient

the insured

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, payments must be made at time of service. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

A return check fee of \$25.00 will be assessed to the patient for any insufficient funds claims.

It is the patient's responsibility to pay for any rendered services, which have not been paid by their respective insurance provider within thirty (30) days of treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on any remaining balance after treatment was completed on all accounts exceeding 30 days.

I understand that there are risks with dental treatment, which involves anesthetic, where numbness may persist indefinitely.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing. I agree to pay all costs and reasonable attorney fees if suit were instituted herunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

* _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

* _____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party