SMILE DESIGN CENTRE

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other
Social Security #: _____ Birth Date: _____
Phone: (Home): _____ (Work): _____ (Cell): _____
Email address: _____
Address: _____
Street City State, ZIP Code

Health History

Date of Last Dental Visit: _____ Reason for this visit: _____
Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Fainting	☐ Nervous Disorders	☐ Tuberculosis	☐ Tumors
☐ Allergies	☐ Glaucoma	☐ Pacemaker	☐ Stroke	☐ Excessive Bleeding
☐ Growths	☐ Pregnancy Due Date: _____		☐ Ulcers	☐ Arthritis
☐ Anemia	☐ Hay Fever	☐ Venereal Disease	☐ Artificial Joints	☐ Asthma
☐ Head Injuries	☐ Radiation Treatment	☐ Heart Disease	☐ Rheumatic Fever	☐ Hepatitis
☐ Respiratory Problems	☐ Heart Murmur	☐ Rheumatism	☐ Blood Disease	☐ Cancer
☐ Liver Disease	☐ Sinus Problems	☐ Jaundice	☐ Smoker	☐ Stomach Problems
☐ High Blood Pressure	☐ Kidney Disease	☐ Diabetes	☐ Dizziness	☐ Mental Disorder

☐ Other Conditions:

☐ Penicillin Allergy ☐ Codeine Allergy ☐ Latex Allergy ☐ Other Allergies:

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 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:

Do you take any medications: ☐ Yes ☐ No
If yes, please list all:

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.

Signature of patient, parent or guardian _____ Date: _____

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Referral Information

Whom may we thank for referring you to our practice: ☐ Our Patient, please provide the name: _____

☐ Yellow Pages ☐ Work ☐ WebSite ☐ Internet ☐ Google, ☐ AACD.com, ☐ YP.com

☐ Other: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____

Address: _____

Street City State, ZIP Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State, ZIP Code

Dental Insurance Information

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

Insured's Date of Birth: _____ ID#: _____ Group#: _____

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: _____

Address: _____

Street City State, ZIP Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This 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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash, or with a debit/credit card, at the time services are performed.

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. As a courtesy, this office will prepare and submit the patient's insurance claims 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.

I understand that the treatment fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. 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 if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I also agree to pay all collection fees if I fail to pay my account balance in full.

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.

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

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