

PATIENT INFORMATION

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Date _____

Patient Name _____

Preferred Name _____

Address _____

City _____ State _____ Zip _____

Sex M F

Date of Birth _____ Age _____

Single Married Divorced Widowed

Employer _____

Occupation _____

Spouses Name _____

Whom may we thank for referring you? _____

What hobbies or interests do you have? _____

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CONTACT INFORMATION

Home Phone _____

Work _____

Cell _____

e-mail _____

How is the best way to contact you? _____
(phone, e-mail, text)

Emergency Contact: _____

Phone #: _____

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RESPONSIBLE PARTY

Who is responsible for this account?

Relationship to Patient? _____

SS# _____

Address _____

City _____ State _____ Zip _____

Phone # _____

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DENTAL INSURANCE

Name of insured _____

SS# _____ DOB _____

Relationship to Patient _____

Insurance Company _____

Policy ID# _____ Group # _____

Ins. Address _____

City _____ State _____ Zip _____

Insurance Phone # _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage and assign directly to Dr. Steven J. Smith and Dr. Morgan J. Smith all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Insured

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OFFICE AGREEMENTS

1. Payment in full for all charges is required at the time of service unless prior arrangements have been made. All delinquent accounts (30 days or older) are subject to reasonable service charges of 18%.
2. The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable by you, the patient.
3. In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (40%) and attorney fees in addition to the balance owed. Any account turned over to a collection agency forfeits any special fees and/or discounts given. Such special fees or discounts will be reversed and you will be responsible for payment of regular procedure fees set at the time the service was performed.

I have read and understand the contents of this agreement.

Responsible Party

Date

MEDICAL-DENTAL HISTORY

Medical Physician's Name _____ Date of last visit _____

Have you ever taken any drugs for osteoporosis such as Fosamax, Actonel, or Boniva? Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
When _____		Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____	
Bleeding abnormally, with	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
extractions or surgery		High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____		Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
When _____		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No

Women:

Are you pregnant? Yes No

Are you nursing? Yes No

If yes, Due date _____

Taking birth control pills? Yes No

MEDICATIONS

List current medications and why you are taking them:

ALLERGIES

Latex

Penicillin

Other _____

Reason for today's visit _____ Date of last dental visit _____

_____ Date of last dental x-rays _____

Reason for changing Dentists _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to hot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____		Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often _____		Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No

Yes No Have you ever had a severe reaction to dental treatment? _____

Yes No Do you have any problems that could be aggravated by reclining in a dental chair? _____

Yes No Would you like a more beautiful, whiter smile than you presently have? _____