

SMITH FAMILY DENTAL
STEVEN J. SMITH, D.D.S. – P.C.
MORGAN J. SMITH, D.M.D.
Cosmetic and Family Dentistry

PATIENT INFORMATION

I. PERSONAL

Patient's Name _____ Date _____

Preferred Name _____ Date of Birth _____ Age _____

Social Security Number _____ Male Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Email _____

Employer _____ Occupation _____

Business Address _____ Phone _____

How is the best way to contact you? _____

Single Married Spouse's Name _____

What hobbies or interests do you have? _____

Person Responsible for Account _____

Relationship _____ Social Security Number _____ Date of Birth _____

Address (if different) _____ State _____ Zip Code _____

Nearest Relative Not Living with You _____

Address _____ Phone _____

Whom may we thank for referring you: _____

Reason for visit: _____

II. INSURANCE: Patient is responsible for all services rendered and charges regardless of insurance coverage:

Primary Insurance: _____

Policy Holder: _____ Date of Birth _____

Policy ID No.: _____ Group No.: _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to this office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangement.
 2. That if payments are extended beyond 90 days from the date of the first billing you agree to pay 1.5% per month on the unpaid balance (annual percentage rate 18%) with a minimum charge of 50 cents per month.
 3. We accept Mastercard, Visa, American Express, Discover Card or Care Credit.
- I / We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Date _____ Person Responsible for Account _____

Signature of Parent _____

I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities.

III. DENTAL-MEDICAL HISTORY

Name of Physician _____ Date of Last Physical _____

- Yes No Are you in good health?
- Yes No Are you under a physician's care? Why? _____
- Yes No May we contact your physician?
- Yes No Women patients- are you pregnant? Due Date _____
- Yes No Are you taking any medication? What? _____
- Yes No Are you allergic to penicillin?
- Yes No Are you allergic to any other drugs? What? _____
- Yes No Do your gums bleed when you brush or floss?
- Yes No Do you have muscle soreness when you chew gum or food?
- 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 Do you use tobacco products? What kind and how often? _____
- Yes No Have you been tested for HIV? Results: Positive Negative
- Yes No Would you like a more beautiful, whiter smile than you presently have?

Do you now have or have you ever had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood transfusion |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood or clotting disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Subject to fainting |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone use |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Yes <input type="checkbox"/> No High blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory disease |

Medical History Updated:

As a courtesy, to reschedule an appointment please notify us as soon as possible to allow our schedule to be adjusted.