PATIENT INFORMATION

1 PATIENT INFORMATION

Date ______________________

Patient Name ______________________

Preferred Name ______________________

Date of Birth ______________ Age ________

Sex ❑ M ❑ F

Spouses / Parents Names ______________________

Whom may we thank for referring you ______________________

____

❑ Single ❑ Married ❑ Other

Address ______________________

City ______________ State ________ Zip ________

Employer ______________________

Occupation ______________________

Hobbies ______________________

2 CONTACT INFORMATION

Home Phone ______________________

Work ______________________

Cell ______________________

e-mail ______________________

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

Emergency Contact: ______________________

Phone #: ______________________

3 RESPONSIBLE PARTY

Who is responisble for this account?

____

Relationship to Patient? ______________________

SS# ______________________

Address ______________________

City ______________ State ________ Zip ________

Phone # ______________________

4 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 benfits 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

5 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

6 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 ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Artificial Joints ❑ Yes ❑ No
When __________
Asthma ❑ Yes ❑ No
Bleeding abnormally, with extractions or surgery ❑ Yes ❑ No
Blood Disease ❑ Yes ❑ No
Blood Transfusion ❑ Yes ❑ No
Cancer ❑ Yes ❑ No
Type __________
When __________
Cortisone Treatments ❑ Yes ❑ No

Diabetes ❑ Yes ❑ No
Epilepsy ❑ Yes ❑ No
Fainting or Dizziness ❑ Yes ❑ No
Heart Problems ❑ Yes ❑ No
Type __________
Hepatitis Type __________ ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Jaw Pain ❑ Yes ❑ No
Pacemaker ❑ Yes ❑ No
Respiratory Disease ❑ Yes ❑ No
Rheumatic Fever ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Lupus ❑ Yes ❑ No

Women:

Are you pregnant? ❑ Yes ❑ No
If yes, Due date __________
Are you nursing? ❑ Yes ❑ No
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 ❑ Yes ❑ No
Tobacco use ❑ Yes ❑ No
Type __________
How often__________
Food collection between teeth ❑ Yes ❑ No

Jaw pain or tiredness ❑ Yes ❑ No
Sensitivity to hot ❑ Yes ❑ No
Sensitivity to cold ❑ Yes ❑ No
Sensitivity when biting ❑ Yes ❑ No
Periodontal treatment ❑ Yes ❑ No
Family history of perio disease or tooth loss ❑ Yes ❑ 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?