**Patient's Name**

____, _____ ___ _____
Title First MI Last

Birthday: ___/___/___ SSN: _____
Home Address:
_____

_____

Employer: _____
Contact:
H: (____) _____ W: (____) _____
C: (____) _____ E-Mail: _____@_____

□ Single □ Married □ Divorced □ Other

In case of emergency please contact.:

Name:_____Phone:_____

Last dental appointment: _____ Dentist: _____

*If patient is under 18 years old:
Parent's Name: ____, _____ ___ _____
Title First MI Last

How did you hear about us? _____

**Dental Insurance #1:**

Insurer's Name: _____ Birthday:___/___/___
SSN: _____ Phone #:_____
Employer: _____ Group #: _____
Insurance Company: _____
*Other Dental Ins. Coverage: _____

**Signature on File**

□ I authorize use of this form on all of my insurance submissions.
□ I authorize the release of information to all my Insurance Companies
□ I understand that I am responsible for the bill.
□ I authorize payment directly to my doctor.
□ I permit a copy of this authorization to be used in place of the original.
□My signature also applies to my dependents.

Signature: _____ Date: _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____
Please Print Name Signature Date

A COPY OF OUR PRIVACY POLICY IS POSTED ON OUR OFFICE WALL FOR YOUR CONVENIENCE, IF YOU WISH TO HAVE A HARDCOPY, PLEASE ASK SOMEONE ON OUR STAFF.

**Consent**
I understand that I am personally responsible for all charges incurred by me, or my dependents in the course of my, our dental treatments. Your Smile agrees to submit to my insurance company for all services and comply with any participating agreements.

**Consent**
Your Smile will not accept insurance payments from non-participating companies as paid in full. I also understand that I am personally responsible to pay for treatment that is denied or not a covered benefit with my insurance. I may be required to prepay co-payments or balances due to prior to scheduling appointment, particularly on longer or more involved treatments.

**Disclaimer:**
I understand that it is my responsibility to keep scheduled appointments. Your Smile requires a 24 hours notification for all cancellations. Failure to provide required notice may result in a $50.00 charge. Payment by cash, check or credit card is due at the time of service. There is a $35.00 returned check fee for all returned checks. A monthly fee of $10.00 will be charged on all accounts over 30 days. In the event of non-payment, patient agrees to pay collection costs including court costs, private process server fees and reasonable attorney's fees.

Signature: _____ Date: _____

## Medical History

*Please check all that apply

- AIDS/HIV Positive
- Alzheimer's Disease
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Blood Pressure: HIGH or LOW
- Breathing Problems
- Cancer/Tumors: _____
- Chemotherapy/Radiation
- Chest Pains
- Congenital Heart Disorder
- Cortisone Medicine
- Diabetes
- Drug/Alcohol Addiction
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Fainting or Dizzy Spells
- Glaucoma
- Heart Attack
- Heart Pace Maker
- Heart Trouble or Disease
- Hepatitis A B C
- Hypoglycemia
- Kidney Problems
- Liver Disease
- Lung Disease
- Pain in Jaw or Joints
- Psychiatric Problems
- Recent Surgery: _____
- Rheumatism
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Thyroid Disease
- Tobacco usage
- Tuberculosis
- Venereal Disease/ S.T.D.'s

**Allergies:**

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Local Anesthetics
- Other:_____

**Women**

- Are you pregnant: □ yes □ no if so, week _____
- Taking oral contraceptives: □ yes □ no
- Nursing: □ yes □ no

**Children**

- Do you have any of the following habits?
  - Thumb/Finger sucking
  - Clenching or Grinding
  - Tongue Thrust
  - Currently bottle fed (at all)
- Is you water fluoridated: □ yes □ no
- Do you still have your wisdom teeth: □ yes □ no
- Would you like to speak to the doctor in private: □ yes □ no

Please list any medications both over the counter and prescription that you are taking:

Please use the following space to inform us of any medical problems not listed or that you may need to further make us aware of:

## Dental History

Do you have any present dental complaints? □ yes □ no _____
When was your last Full Mouth Xray (or Panorex) taken? _____ Where? _____
When was your last dental cleaning? _____ Where? _____
Have you ever had periodontal disease? _____ How many times a week do you floss? _____ How many times a day do you brush? _____
*Do you like your smile? □ yes □ no What would you change? _____

***To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It's my responsibility to inform the dental office of any changes in my medical status.**

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

**Doctor Notes:**