Smile DENTAL CLINIC

Patient Registration

(Circle One): Dr / Mr / Mrs / Ms / Miss
First Name: _____ Middle: _____ Last Name:_____
Street Address: _____ City: _____ State:_____ Zip:_____
Cell Phone: _____ Home Phone: _____
Email Address: _____
Patient Social Security #: _____-_____-_____
Patient Date of Birth: _____ Sex: (circle) **M / F**
Emergency Contact: _____ Phone: _____
Preferred Pharmacy #: _____
How did you hear about us? ☐ TV ☐ Internet ☐ Referral ☐ Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes / No**
Do you have Secondary Dental Insurance? (circle) **Yes / No**

Primary Insured		**Secondary Insured**	
Policyholder Name		Policyholder Name	
Policyholder SSN		Policyholder SSN	
Date of Birth		Date of Birth	
Relationship to Patient	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Patient	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

Please present your insurance card to our front desk to be photocopied

Health History

Before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Reason for today's visit? _____
Date of last dental visit: _____ Date of last dental x-rays: _____ Date of last cleaning: _____
Date of Last Physical: _____ Physician's Name & Phone #: _____
Have you ever been or are you under the care of a physician? (circle) **Yes / No**
➔ For what condition(s)? _____
Have you ever been hospitalized? (circle) **Yes / No**
Height: _____ Weight: _____
Have you ever been treated for periodontal (gum) disease? (circle) **Yes / No**

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Are you interested in tooth whitening? (circle) **Yes / No**
If wearing dentures, age of dentures: _____ Are you interested in new dentures? (circle) **Yes / No**
Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes / No**
Are you taking or have taken Oral Bisphosphonates (e.g., FOSAMAX, ACTONEL, BONIVA) or IV Bisphosphonates (e.g., ZOMETA, AREDIA)? (circle) **Yes / No** Taken for how long? _____
Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes / No**
Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes / No**

List any medications you are allergic to:
1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:
1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Pacemaker/Heart Surgery			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:_____)		
Any type of Transplant			Heart Problem (_____)			Excessive Bleeding			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type: ____)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Tobacco Use			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated delivery date: ____/____/____			Are you taking any birth control prescriptions?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated.

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Patient's Signature _____ Date _____

Financial Policies

A Clear, Written Estimate on the Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate on the cost of your treatment plan in writing so you know what to expect, including your estimated insurance benefits. If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

Payment Policy

- Payment in full is due before services are rendered. Acceptable forms of payment include cash, Visa®, MasterCard®, American Express®, assigned insurance benefits and select third-party financing programs.
- For comprehensive treatment plans requiring multiple office visits, a minimum deposit is required.
- You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans.

Dental Insurance

If you have dental insurance, your insurance claim will be processed as follows:

- In Network: If your dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist's agreement with your insurer.
- Out of Network: If your dentist is not a participating or in-network provider with your insurance plan, we will honor your carriers in network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.

Financial Policies

By signing below, I acknowledge that I read the Financial Policies page and agree to abide by such policies.

Signature _____ Date _____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Notice of Privacy Practices (must be signed by ALL new patients). By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature _____ Date _____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance). To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled)

(Circle One): Dr / Mr / Mrs / Ms / Miss
First: _____ Middle: _____ Last: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Signature _____ Date _____