**Patient Information**

Prefix: \_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male Female Unspecified E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Social Security No.: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Employer Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician Name and Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy Name and Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you like to receive reminders? Phone Text E-mail

How did you hear about Smart Dental? Ad Web search Friend/family Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance**

Is the subscriber the same as the patient? Yes No

**Subscriber Information**

Prefix: \_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male Female Unspecified E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Social Security No.: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Employer Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Subscriber: Child Spouse Disabled Dependent Other: \_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID/Policy No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health History**

|  |  |  |  |
| --- | --- | --- | --- |
| **DENTAL HISTORY** | | **Yes** | **No** |
| Last Dental Exam Date: | | | |
| Last Dental X-Ray Date: | | | |
| Reason for this visit: | | | |
| Do you wear dentures? | |  |  |
| Have you had any gum treatments? | |  |  |
| Have you worn braces of Invisalign? | |  |  |
| Do your gums bleed or feel irritated or tender? | |  |  |
| Are you aware of grinding or clenching your teeth? | |  |  |
| Do you use dental floss regularly? | |  |  |
| Are you happy with the color of your teeth? | |  |  |
| Are you happy with your smile? | |  |  |
| Are you interested in braces or Invisalign? | |  |  |
| **MEDICAL HISTORY** | | | |
| Last Medical Exam Date: | | | |
| Do you have any current health problems? If yes, please explain: | |  |  |
| Are you currently under a physician’s care? | |  |  |
| Are you currently taking any blood thinner medications or Aspirin? | |  |  |
| Do you need premedication? | |  |  |
| Are you pregnant? If yes, how many weeks: | |  |  |
| Do you use tobacco (cigarettes, e-cigs, pipe, chewing)? | |  |  |
| Are you allergic or have you had an adverse reaction to any of the following?  **None** Aspirin Amoxicillin Codeine Epinephrine Erythromycin Latex Lidocaine Metals Novocain Penicillin Sulfa Tetracycline Seasonal allergies   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Is there any other medical or dental information that you feel we should know about? If yes, please explain: | |  |  |
| Please list all current medications: | | | |
| Height: ft. in. | Weight: lbs. | | |

**Please check ‘Yes’ or ‘No’ if you have or have had any of the following.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Y | N |  | Y | N |  | Y | N |
| Abnormal bleeding |  |  | Frequent headaches |  |  | Radiation treatment |  |  |
| AIDS/HIV |  |  | Glaucoma |  |  | Rapid weight gain/loss |  |  |
| Alcohol abuse |  |  | Heart attack |  |  | Respiratory disease |  |  |
| Anemia |  |  | Heart surgery |  |  | Seizures |  |  |
| Arthritis |  |  | Hepatitis  A B C |  |  | Shingles |  |  |
| Artificial heart valves |  |  | Herpes |  |  | Shortness of breath |  |  |
| Artificial bones |  |  | High blood pressure |  |  | Skin rash |  |  |
| Artificial joints |  |  | High cholesterol |  |  | Spina bifida |  |  |
| Asthma |  |  | Jaw pain |  |  | Stroke |  |  |
| Cancer |  |  | Kidney disease |  |  | Surgical implant |  |  |
| Chemotherapy |  |  | Liver disease |  |  | Swelling of legs/feet |  |  |
| Cortisone treatment |  |  | Low blood pressure |  |  | Thyroid disease |  |  |
| Diabetes  Type I Type II |  |  | Nervous system disease |  |  | Tuberculosis |  |  |
| Epilepsy |  |  | Psychiatric care |  |  | Ulcers/Colitis |  |  |

**Financial Policy**

The above information is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor if I, or my dependents, ever have a change in health. I certify that I have insurance coverage and authorize payment directly to Smart Dental for benefits, otherwise payable to me. I understand that I am financially responsible for all charges for myself and/or my dependents, whether or not paid by insurance, due and payable at the time services are rendered. I authorize the use of my signature on all insurance submissions.

As a courtesy, we will gladly provide an estimate of your co-pay. Your exact co-payment will be determined by **Your Insurance Carrier** as your claim is processed. All incurred charges are ultimately the responsibility of the patient, regardless of insurance coverage.

It is the policy of Smart Dental to charge a broken or missed appointment fee of $25.00 per half hour for appointments not canceled with at least a 24 hour notice. Returned checks are subject to a $35.00 fee. Any account that has not received payment in 90 days will be sent to a collection agency. All collection costs and legal fees for both parties are the responsibility of the account holder. Any balance over 90 days will be subject to a 1.5% monthly finance charge.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Signature of Parent/Guardian if patient is a minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_