SMILE DESIGN CENTER

Patient Information

Patient name: _____ Date: _____
Last First MI

Birth date: _____ Sex: ☐ Male ☐ Female ☐ Other / prefer not to say

Marital status: ☐ Married ☐ Single ☐ Child ☐ Other

Cell phone: _____ Home: _____ Work: _____

Email: _____

Address: _____
Street City State, ZIP code

How may we contact you?

☐ Text messages to my cell phone (appointment reminders and office messages; message and data rates may apply; reply STOP at any time to opt out)

☐ Email ☐ Voicemail messages are OK

Health History

Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check all that apply:

☐ HIV / AIDS	☐ Fainting	☐ Nervous disorders	☐ Tuberculosis	☐ Tumors
☐ Allergies	☐ Glaucoma	☐ Pacemaker	☐ Stroke	☐ Excessive bleeding
☐ Growths	☐ Hay fever	☐ Ulcers	☐ Arthritis	☐ Asthma
☐ Anemia	☐ Head injuries	☐ STDs	☐ Joint replacement	☐ Hepatitis
☐ Heart disease	☐ Heart murmur	☐ Rheumatic fever	☐ Rheumatism	☐ Blood disease
☐ Cancer	☐ Radiation treatment	☐ Respiratory problems	☐ Liver disease	☐ Sinus problems
☐ Jaundice	☐ Stomach problems	☐ High blood pressure	☐ Kidney disease	☐ Diabetes
☐ Dizziness	☐ Mental health condition	☐ Osteoporosis	☐ Sleep apnea	☐ Other:

Pregnant? ☐ Yes ☐ No Due date: _____ Other conditions: _____

Allergies: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local anesthetic Other allergies: _____

Tobacco / nicotine: ☐ None ☐ Smoke ☐ Vape ☐ Chew Alcohol, drinks per week: _____

Do you take a blood thinner (such as aspirin, Plavix, Eliquis, Xarelto or warfarin)? ☐ Yes ☐ No

Have you ever taken medication for osteoporosis or cancer (such as Fosamax, Boniva, Actonel, Reclast, Prolia or Xgeva)? ☐ Yes ☐ No

If yes, which and when: _____

Do you take any other medications or supplements? ☐ Yes ☐ No

If yes, please list all: _____

_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you under the care of a physician? ☐ Yes ☐ No

Physician's name: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my health or medications ever change, I will inform the doctor at my next appointment.

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

How Did You Hear About Us?

☐ Google search ☐ Google ad ☐ Google Maps ☐ Facebook / Instagram ☐ AACD.com ☐ Our website ☐ Work

☐ Our patient — name: _____ ☐ Another dentist — name: _____

☐ Other: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ Birth date: _____

Relationship to patient: _____ Cell phone: _____ Other phone: _____

Email: _____

Address: _____

Street City State, ZIP code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer: _____ Occupation: _____

Employer address: _____

Dental Insurance Information

Name of insured: _____ Insured's date of birth: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Is the insured a patient? ☐ Yes ☐ No

Insurance company / plan: _____ Insurance phone: _____

Member ID #: _____ Group #: _____

Insured's employer: _____

Insured's address, if different from patient: _____

Please bring your insurance card to your first visit.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, and any dental services performed without previous financial arrangements, must be paid for in cash or by debit or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of all dental services. As a courtesy, this office will prepare and submit the patient's insurance claims or assist in making collections from insurance companies, and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the treatment fee estimate for this dental care is valid for six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of those services to the doctor, or his assignee, at the time the services are rendered, or within five (5) days of billing if credit is extended. I further agree that the reasonable value of the services shall be as billed unless I object in writing within the time for payment. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I agree to pay all costs and reasonable attorney fees if suit is brought hereunder. I also agree to pay all collection fees if I fail to pay my account balance in full.

I give my permission to you or your assignee to call me at home, at work or on my cell phone, and to text me if I selected text messages above, to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian: _____ Date: _____ Relationship to patient: _____

Signature of guarantor / responsible party: _____ Date: _____ Relationship to patient: _____