Smile Center - Patient Registration

Today's Date: __________

Patient's Name____________________________________ Preferred Name: _________________

Birthdate__________ Social Security #____________ Age__________ Sex: M_______ F_______

Select One: Single ______ Married ______ Other _______ Email: ___________________________

Street Address: ____

City_______________________ State _______________________ Zip ______________________

Preferred Method of Communication (Circle One): Cell Phone Home Phone Email Text

Cell Phone________________ Home Phone _______________ Work Phone __________________

Patient T-Shirt Size___________

Employer? ________________________ Are you a Full Time Student? Y ___ N____

Emergency Contact ___________________ Relationship_____________ Phone# _______________

If patient is a minor (18 and under):

Mother's Name ____________________Date of Birth______________ Phone Number___________

Father's Name ____________________ Date of Birth______________ Phone Number__________

*Please list other adults who may accompany the minor to appointments:

Name ____________________ Relationship _________________ Phone Number ______________

Name ____________________ Relationship _________________ Phone Number ______________

Person Responsible for Account (if other than patient)

Name ________________________________ DOB ________________ SS# __________________

Street Address ________________________ City ______________ State __________ Zip _______

Best Contact Number __________________________________ Employer ____________________

How did you hear about our office? ______ Yellow Pages ______Office Sign _____ Post Card

Family/Friend name ______________Facebook ____ Billboard_____ Website_____ Other_____

*****Dental Insurance-*** Please present card at desk upon arrival. Copy of card will be kept on file and updated annually.

PATIENT MEDICAL HISTORY

Do you have any current medical problems or are you under a physician's care? No ______ Yes _________

If yes, please list/what for: ____

What MEDICATIONS (including over-the-counter) do you take? ______________________________________

____

Women: PREGNANT? No ________ Yes, due date: __________

Do you SMOKE? No ________ Yes;#Pack/Day _________ Other tobacco? ______________

CIRCLE Any of the following which you have had or presently have:

Artificial Heart Valve	A.I.D.S./HIV Positive	Tuberculosis
Congenital Heart Lesions	Hepatitis A (Infectious)	Asthma
Heart Surgery/Heart Transplant	Hepatitis B (Infectious)	Sinus Trouble
Artificial Joints (Hip, Knee)	Hepatitis C	Allergies or Hives
Infective Endocarditis	Rheumatic Fever	Diabetes
Kidney Trouble	Hemophilia (Bleeding Problems)	Thyroid Disease
Mitral Valve Prolapse	Chemotherapy	Ulcers
Heart Disease or Attack	(Cancer, Leukemia)	Epilepsy/Seizures
High Blood Pressure	Radiation Treatment	Arthritis
Angina Pectoris	Fever Blisters	Glaucoma
Stroke	Venereal Disease	Emphysema
Heart Murmur	Herpes	Drug Addiction
Heart Pacemaker	Liver Disease	

CIRCLE Are you allergic or have you reacted adversely to:

Latex	Local Anesthetic	Penicillin
Aspirin	Codeine	Erythromycin
Nitrous Oxide (Gas)		

*Are you aware of being allergic to any other medications or substances? No ______ Yes _______

If yes, please list____

Who is your physician? ________________________

PATIENT DENTAL HISTORY

How long since you have seen a dentist? __________ Present dental health: GOOD FAIR POOR

Are you having any problems now? No _____ Yes _____

Are you afraid or nervous about dental treatment? No _____ Yes _____

Do your gums bleed, feel tender, or irritated? No ______ Yes _____

Are your teeth sensitive to hot, cold, sweets, pressure? No ______ Yes _____

Are you unhappy with the appearance of your teeth? No ______ Yes _____

Are you aware of grinding or clenching your teeth? No ______ Yes _____

Do you have discolored teeth that bother you? No ______ Yes _____

Do you have headaches, earaches, or neck pains? No ______ Yes _____

Would you like your smile to look better or different? No ______ Yes _____

Do you regularly use dental floss? No ______ Yes _____

How do you feel about your teeth? ____

Financial Policy
We are grateful that you have chosen us as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides you the very best of care in the most pleasant environment possible.

Payment is due the day of service and we offer several options for your convenience. We accept cash, checks, Visa, MasterCard, and Discover, as well as extended payment plans with no interest upon credit approval. We offer a 5% discount on major work (crowns, bridges, dentures, etc.) when paid in full by cash, check or credit card at the time of service. In the event that your account becomes delinquent, an effort will be made to form a payment arrangement, to bring the account into good standing. If no arrangement can be agreed upon, your account will be turned over to a third party collection company.

Initials______

Dental Insurance
We are happy to accept assignment of insurance benefits from you insurance company. As a courtesy to you, we will files your insurance and help you maximize your benefits. We will estimate your insurance coverage and your portion for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from you insurance carrier.

It is very important to note that the balance on your account is your responsibility regardless of your carrier's coverage.

Initials______

Missed and Changed Appointments
Please help us serve you and all our patients best by keeping your scheduled appointments. We will attempt to contact you to remind you of an upcoming appointment via text message (if you're enrolled in the service), email and by phone. Please let us know by confirming that date and time still work well with your schedule. If it is necessary to reschedule an appointment, please give us a minimum 48 hours notice. If sufficient notice is not given, your account will automatically be charged a $35 missed appointment fee. We ask that you make every effort to keep your reserved time.

Initials______

Photo Release
Smile Center takes photos for various reasons including education, diagnosis, treatment, and proof for insurance as well as testimonials. Please initial below to indicate your release of photos.

Initials______

Summary of Notice of Privacy Practices
Smile Center keeps a record of every visit you make to our office and we are committed to protecting the health information that is in that record. Typically, the record contains information regarding your health and dental health along with our professional impression, diagnosis and treatment. The record belongs to Smile Center but the information in it is yours.

Smile Center "Notice of Privacy Practices" is a detailed explanation of how we may use your health information and your right to inspect, copy, and amend what is recorded. We are required by law and by our own code of ethics to keep the information about you private, to give you a copy of this "Notice" and to follow the practices outlined in the "Notice."

You have the right to a copy of this "Notice." Please check your option below.

- I am requested a copy of Smile Center "Notice of Privacy Practices."
- I do not wish to receive a copy of Smile Center "Notice of Privacy Practices" at this time. I reserve the right to request a copy at a later date.

Whom may we share your confidential information with? ______________________________________

By signing this form, I acknowledge that I have read and understand the policies of Smile Center.

Signature ____ Date ________________________

Printed Name ____