Smile Rite II

Welcome

TODAY'S DATE:_____

Please print: **Patient Information (CONFIDENTIAL)** Home Phone# _____

Cell Phone #_____

Name_____ Date of Birth _____

Address_____City_____State_____Zip Code_____

SS#_____ Check appropriate box: ☐Minor ☐Single ☐Married ☐ Other

Patient's Employer/School _____Work Phone_____

Email Address_____

Person to contact in case of emergency_____ Phone_____

Whom may we thank for referring you?_____☐ Family ☐ Friend

Please check one: ☐Insurance ☐Google ☐Yelp ☐Internet ☐Newspaper ☐T.V. ☐Yellowbook

☐ **SELF** **Responsible Party (Ex: parents, caregiver, nursing home, P.O.A, etc.)**

Person responsible for this account_____ Relationship to Patient _____

Address_____

Home Phone_____ Soc. Sec. No._____ Birth Date_____

Employer_____Work phone_____

Dental Insurance Information:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birth Date _____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Dental Insurance Co. _____Group No._____

Ins. Co. Address_____ City_____ State _____Zip code_____

Do you have additional dental insurance? If yes complete the following:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birth Date _____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Dental Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Are you under medical treatment now? ☐ YES ☐ NO

Have you ever been hospitalized for any surgical operations or serious illness? ☐ YES ☐ NO

Are you taking any medication(s) including non-prescription medications? ☐ YES ☐ NO

If yes, please list all medications you are currently taking:

_____

_____

_____

_____

Do you use tobacco? ☐ YES ☐ NO

Do you use alcohol, cocaine or other drugs? (Circle) ☐ YES ☐ NO

Do you take an aspirin daily? ☐81mg ☐325mg ☐ YES ☐ NO

Are you allergic to any of the following:

- ☐ No Known Allergies
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local anesthetics (ex. Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Iodine
- ☐ Latex
- ☐ Other _____

Anemia	☐ YES ☐ NO	Heart attack	☐ YES ☐ NO	Leukemia	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Heart disease	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Low blood pressure	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO	Pace Maker	☐ YES ☐ NO
Cardiac pacemaker	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Radiation Therapy	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	High Cholesterol	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	HIV/AIDS	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Epilepsy/Convulsions.	☐ YES ☐ NO	Kidney Diseases	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO

Women ONLY:

Are you pregnant or think you may be pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

Are you taking birth control? ☐ YES ☐ NO

Are your teeth sensitive to hot, cold, sweet or sour liquid/food? ☐ YES ☐ NO

Do you feel pain in any of your teeth? ☐ YES ☐ NO

Have you ever had difficult extractions in the past? ☐ YES ☐ NO

Have you ever had prolonged bleeding following and extraction? ☐ YES ☐ NO

Are you currently wearing dentures? ☐ YES ☐ NO

Age of existing dentures:_____ years old

Date of last x-ray series is _____ How many were taken?_____

Office Policies

Please read and Initial each of the following statements to accept the terms and conditions .

_____We ask that you do not reschedule more than 2 appointments without giving 24 hours' notice or a missed appointment fee will be charged .

_____ You may not have more than one missed appointment in a 12 month period to maintain the privilege of scheduling an appointment. (We value your health and we will be happy to serve you on a walk-in basis)

_____ All charges on your account are your responsibility regardless of insurance coverage. Unpaid insurance balances older than 60 days will become your responsibility. All fees quoted are estimates only and are based upon available benefits, current eligibility and are not a guarantee of payment from your insurance provider.

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status and personal information. I authorize the dental staff to perform the necessary dental service I may need. I certify that I am covered by _____ Insurance Co. and I assign directly to this dental office all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing my signature, I have read and understand all of the above.

Signature:_____Date:_____