WELCOME TO ELITE SMILES DENTAL!

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Patient's Date of Birth: _____

Patient's Address: _____ Patient's Social Security #: _____

_____ Patient's Phone #: _____

_____ Cell Phone #: _____

Patient's Age: _____ Sex: _____ Marital Status: _____

Email:_____ (will only be used for office communications)

Who may we thank for referring you?_____ Emergency Contact (name and phone)_____

RESPONSIBLE PARTY

Responsible Party: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Phone#: _____

_____ Cell Phone #: _____

Relationship to Patient: _____ Work Phone #: _____

Email:_____(will only be used for office communications)

Is this person currently a patient in our office?_____

For you convenience, we currently offer the following methods of payment. Please check the option you prefer for payment in full at each appointment:

Cash_____ Personal Check_____ Credit Card_____ I wish to discuss the office payment policy_____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone: _____

Address: _____ Union or Local #: _____

_____ Group #: _____

Insurance Company: _____ Phone #: _____

Address: _____ Member #:_____

_____ Family/Single Coverage: _____

ADDITIONAL INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Employer: _____ Social Security #: _____

Insurance Company: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Group #: _____

PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____ Date of Last Exam: _____

Have you ever been told you have one of the following? Check only if answer is yes.

___ Heart Disease
___ Heart Attack
___ Heart Murmur
___ Chest Pain –Angina
___ Congenital Heart Defect
___ Rheumatic Fever
___ High Blood Pressure
___ Low Blood Pressure
___ Stroke
___Thyroid Disease
___ Stomach Ulcer
___ Mitral Valve Prolapse
___ Sexually Transmitted Disease

___ Anemia
___ Bleeds Easily
___ Fainting/Seizures
___ Epilepsy/ Convulsions
___ Arthritis
___ Joint Replacement/Implant
___ Liver Disease
___ Hepatitis
___ Jaundice
___ Glaucoma
___ Leukemia
___ AIDS/HIV
___ Kidney Disease

___ Asthma
___ Shortness of Breath
___ Swollen Ankles
___ Hay Fever/Allergies
___ Emphysema
___ Recent Weight Loss
___ Diabetes
___ Cancer
___ Radiation Therapy
___ Psychiatric Treatment
___ Other _____
_____
_____

Do you have any medication allergies, if so please list_____

Yes NO
___ ___ 1. Are you under medical treatment now? Why: _____
___ ___ 2. Have you ever had any other serious illness not listed above? What: _____
___ ___ 3. Are you currently taking any medications? What: _____
___ ___ 4. Have you ever had a bad reaction to local anesthetic or penicillin? What: _____
___ ___ 5. Do you use tobacco? _____
___ ___ 6. Do you use Alcohol, Cocaine or other drugs? What: _____
___ ___ 7. Women Only: Are you pregnant or think you may be pregnant? What month:_____
Are you taking birth control pills?_____

PATIENT DENTAL HISTORY

Name of previous dentist_____Date of Last Exam_____
Previous dentist location_____ Date of Last Cleaning_____

What is your reason for seeking care at this time: _____
Do you have any pain or discomfort now? If so what: _____
Do your gums bleed? _____ Have you had surgery preformed on your gums? _____
Have you ever had a root canal? _____Have you ever worn braces? _____ Do you wear Dentures?_____
Do you clench or grind your teeth?_____Have you ever had any trauma to your face or mouth? _____
Do you floss? How often _____ How many times a day do you brush your teeth? _____
Are your teeth sensitive to hot or cold liquids?_____ Are your teeth sensitive to sweet or sour liquids/foods?_____
Do you have any sores or lumps in or near you mouth?_____ Do you like your smile?_____
Have you ever had prolonged bleeding after extractions?_____ Do you bite your lips or cheeks frequently?_____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

_____ Date: _____
Signature of Patient/Parent or Guardian

DOCTOR'S COMMENTS:_____

_____

_____Signature and date:_____