Welcome to Elite Smiles Dental!

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

_____ Cell Phone #: _____

Age: _____ Sex: _____ Marital Status: _____

E-mail: _____ (will only be used for office communications)

If you were referred to our office by a current patient outside of your immediate family, our CARE TO SHARE program allows you both to earn a $25 credit on both of your accounts! *Whom may we thank for referring you?* _____

RESPONSIBLE PARTY/EMERGENCY CONTACT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Home Phone #: _____

_____ Cell Phone #: _____

Relationship to Patient: _____ Work Phone #: _____

E-mail: _____ (will only be used for office communications)

Is this person currently a patient in our office? _____

For your convenience, we currently offer the following methods of payment. Please check the option you prefer for your estimated portion at each appointment:
Cash ____ Check ____ Credit Card (Visa/MasterCard/Discover/AMEX) ____ Care Credit ____ I would like to discuss my options ____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone #: _____

Address: _____ Union or Local #: _____

_____ Group #: _____

Insurance Co: _____ Phone #: _____

Address: _____ Member ID #: _____

_____ Family/Single coverage: _____

SECONDARY INSURANCE (if applicable)

Policy Holder: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Employer: _____ Phone #: _____

Address: _____ Union or Local #: _____

_____ Group #: _____

Insurance Co: _____ Phone #: _____

Address: _____ Member ID #: _____

_____ Family/Single coverage: _____

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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	___ Anemia	___ Asthma	___ Heart Murmur	___ Congenital Heart Defect
___ Bleeds Easily	___ Swollen Ankles	___ Heart Attack	___ Shortness of Breath	___ Joint Replacement/Implant
___ Fainting/Seizures	___ Swollen Ankles	___ Arthritis	___ Chest Pain - Angina	___ Sexually Transmitted Disease
___ Hay Fever/Allergies	___ Emphysema	___ Cancer	___ Epilepsy/Convulsions	___ Psychiatric Treatment
___ Kidney Disease	___ Rheumatic Fever	___ Diabetes	___ High Blood Pressure	___ Radiation Therapy
___ Liver Disease:	___ Stomach Ulcer	___ Stroke	___ Low Blood Pressure	___ Mitral Valve Prolapse
___ Hepatitis	___ Thyroid Disease	___ Glaucoma	___ Leukemia	___ AIDS/HIV
___ Jaundice	___ Other: _____			

Do you have any allergies to any medications? _____

YES	NO	
_____	_____	Are you under any medical treatment now? Please explain: _____
_____	_____	Have you ever had any other serious illness not listed above? Please explain: _____
_____	_____	Are you currently taking any medications? Please explain: _____
_____	_____	Have you ever had a bad reaction to local anesthetic or penicillin? Please explain: _____
_____	_____	Do you use tobacco? Please explain: _____
_____	_____	Do you use alcohol, cocaine, or other drugs? Please explain: _____
_____	_____	*For women only:* Are you pregnant or think you may be pregnant? What month: _____
_____	_____	*For women only:* Are you currently taking birth control pills? _____

PATIENT DENTAL HISTORY

Name of Previous Dentist: _____ Date of Last Exam: _____
Location: _____ Date of Last Cleaning: _____
What is the reason for your visit today? _____
Do you have any pain or discomfort now? Please explain: _____
Do your gums bleed? _____ Have you ever had surgery performed 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 per day 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 around your 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.

_____ _____
Signature of Patient/Parent or Guardian Date

Doctor's Comments: _____

_____

_____ Signature and Date: _____