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: _____ Work Phone #: _____

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

Whom may we thank for referring you? _____

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!

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 ____ Visa/MasterCard/Discover/AMEX ____ Care Credit ____ I would like to discuss my options ____

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? _____

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 INFORMATION (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	____ AIDS/HIV
____ 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	____ Sexually Transmitted Disease:
____ Jaundice	____ Other: _____			_____

Do you have any allergies to any medications? _____

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

PATIENT DENTAL HISTORY

Previous Dentist: _____ Phone #: _____ 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 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. I authorize and request my insurance company to pay directly to Elite Smiles Dental any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and Elite Smiles Dental has no leverage on assuring that my claims will be paid as estimated. As a courtesy to their patients, Elite Smiles Dental completes and files my insurance claims for me. I understand that I am responsible for any unpaid or denied claims. *Thank you for understanding that as your dental care provider, our relationship is with you and not with your insurance company.*

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 understand that Elite Smiles Dental complies with all HIPAA policies and regulations and that I may request a detailed outline of such policies.

_____	_____	_____
(Please Print) Name of Patient	Signature of Patient/Parent or Guardian	Today's Date

_____

Signature of Treating Dentist