PATIENT REGISTRATION
(PLEASE PRINT)

Name: _____Birthdate: _____
Address: _____City: _____State: _____Zip: _____
Cell Phone: _____Home Phone: _____Email: _____
Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Separated □ Domestic Partner □ Widowed
Social Security #: _____ Employer: _____ Phone: _____
Spouse, partner or parent name: _____ Phone: _____
Person to contact in case of an emergency: _____
Person responsible for this account? (If different from above) _____
How did you learn about our practice or whom may we thank for referring you? _____

Dental Insurance

Insurance Company: _____Phone: _____
Subscriber's Social Security #_____ID #_____Group # _____
Subscribers Name: _____

Dental History

Reason for today's visit: _____Date of last dental care visit: _____
Former dentist's name: _____ Phone: _____
Check if you have any problem with the following:
□ Bad breath □ Bleeding gums □ Clicking or popping jaw □ Food collection between teeth □ Grinding teeth
□ Loose teeth or broken fillings □ Periodontal treatment □ Sensitivity to cold, hot, sweets □ Sensitivity when biting
How often do you floss? _____How often do you brush? _____

Medical History

Your Physician: _____ Date of last visit: _____
Any history of drug use: _____ Any drug allergies or have had an adverse reaction: _____
Have you had any serious illnesses or operations? □ Yes □ No
If yes, describe: _____
List medications you are currently taking: _____
Women: are you pregnant? □ Yes □ No Are you taking birth control? □ Yes □ No

Check if you have or have had any of the following:

□ Allergies to medicine or drugs
□ Anemia
□ Anticoagulants (blood thinners)
□ Arthritis, rheumatism
□ Artificial heart valves
□ Artificial joints, pins, etc.
□ Asthma
□ Back problems
□ Blood disease
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory problems
□ Diabetes
□ Emphysema
□ Epilepsy
□ General allergies
□ Headaches
□ Heart Murmur
□ Hemophilia
□ Hepatitis
□ High blood pressure
□ HIV/AIDS
□ Jaw pain
□ Kidney disease
□ Liver disease
□ Mitral valve prolapse
□ Nervous problems
□ Osteoporosis
□ Pacemaker
□ Psychiatric care
□ Radiation treatment
□ Respiratory disease
□ Rheumatic fever
□ Sinus problems
□ Snore/sleep apnea
□ Stroke
□ Thyroid
□ Tobacco use
□ Tuberculosis
□ Ulcer

ACKNOWLEDGMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing or processing of insurance for benefits for which I am entitled. I will not hold Smile Concepts and its owners, agents, and/or employees responsible for any errors or omissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT TIME OF SERVICE. In the event of default of payment, my account may be turned over to the collection agency and I will be liable for all late fees, court costs, attorney fees and/or collection fees incurred.

Signature of Responsible Party_____**Date**_____

PATIENT, PARENT OR AGENT MUST BE 18 YEARS OR OLDER