

. :: Perfect Smile Dental :: .

Patient Information

Date _____

Patient Name _____
Last Name

First Name Middle Initial

SS/HIC/PATIENT ID # _____

Address _____

City _____

State _____ ZIP _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorce Partnered for _____ years

Occupation _____

Patient Employer/School _____

Email Address _____

Preferred Spoken Language _____

Spouse's Name _____

Birthdate _____ SS# _____

Whom may we thank for referring you? _____

** Appointment Cancellation Fee : **

If for any reason you could not make it to your appointment, please give us a call to cancel 24 hours in advance, otherwise there will be a \$25.00 cancellation fee charged to your account!!

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company (ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Best time and place to reach you _____ Morning Afternoon Evening Anytime

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of the mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/ State _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last x-rays _____	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you had any of the following:	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth. <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
		Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No

Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	_____
Blister on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss?	_____
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush?	_____

Health History

Physician's Name _____ Date of last visit _____

Are you now under the care of a physician? ()Yes ()No

If yes, please explain: _____

Have you ever had any complications following dental treatment? ()Yes ()No

If yes, please explain: _____

Have you been admitted to the hospital or needed emergency care during the past two years? ()Yes ()No

If yes, please explain: _____

Do you have any health problems that need further clarification? ()Yes ()No

If yes, please explain: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" Yes No

These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever experienced any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | Medication: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | Other : _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | Due Date: _____ | |

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

Allergies

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
 If I ever have any change in my health, I will inform the doctors at the next appointment without fail. _____ (Please Initial)

Consent For Services

As a condition of your treatment by the office, financial agreements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However this office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written arrangements are satisfied.

I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional service rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment

thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their consent.

Signature of Patient, Parent or Guardian

Date

Relationship to Patient

Signature of Guarantor of Payment Responsible Party

Date

Relationship to Patient