smile concept

SMILE CONCEPT WELCOMES YOU!

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you. Thanks for being our patient!

1. Patient Information

First Name _____ Last Name _____ MI _____

Preferred Name _____ Title _____

Male ☐ Female ☐ Single ☐ Married ☐ Other ☐

Date of Birth _____ SSN _____

Driver's Lic. _____ State _____ (Photocopy required)

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile Phone _____

E-mail _____ Alternate E-mail _____

Occupation _____

Employer _____ Work Phone _____

Emergency Contact Name _____ Phone _____

How did you hear about us? _____

2. Insurance Information

Primary Dental Carrier

Subscriber Name _____ SSN/ID _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone _____ Group Number _____

Relation to Patient _____

Secondary Dental Carrier

Subscriber Name _____ SSN/ID _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone _____ Group Number _____

Relation to Patient _____

Assigment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship to Patient _____ Date _____

3. Medical History & Information

	YES	NO
ADHD		
Allergies (Seasonal)		
Anemia		
Angina		
Arthritis		
Artificial Joint(s)		
Asthma		
Blood Transfusion		
Blood Disorder		
Cancer		
Diabetes		
Drug / Alcohol Abuse		
Emphysema		
Epilepsy /Fainting		
Fever Blister		
Headaches / Migraines		
Gastrointestinal Problems		
Glaucoma		
HIV+ / AIDS		
Heart Murmur		
Heart Disease		

	YES	NO
Hepatitis A B C (Specify)		
Hormone Deficiency		
High Blood Pressure		
High Cholesterol		
Immunosuppression		
Kidney Disease		
Liver Disease		
Low Blood Pressure		
Lung Disease		
Osteoporosis		
Psychiatric Problems		
Rheumatic Fever		
Seizures		
STD / Venereal Disease		
Shingles / Chicken Pox		
Sinus Problems		
Speech / Hearing Impairment		
Stroke		
Thyroid Problems		
Tuberculosis		
Other _____		

Allergies	YES	NO
Aspirin		
Codeine		
Dental Anesthetics		
Erythromycin		
Iodine		
Latex		
Metals		
Penicillin		
Sulfa		
Tetracycline		
Other _____		

For Women		
Are you taking birth control pills?		
Are you pregnant?		
If yes, how many weeks _____		
Are you nursing?		
Are you undergoing hormone therapy?		

Do you use tobacco products? _____

Have you ever taken Fosamax, Boniva, Actonel or any products that containing biophosphonates? _____

Please list any medications you are currently taking: _____

_____

Treatment Authorization

I authorize the SMILE CONCEPT dental team to perform dental services that I may need and have consented to during diagnosis and treatment, including the use of local anesthesia and other medication. I certify that the medical information provided on this page is current and accurate to the best of my knowledge.

Patient Signature _____ Date _____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient Signature _____ Date _____

Authorization To Release Health Information

☐ I **DO NOT** authorize the practice to release my health information to anyone except for my insurance carrier.

☐ I authorize the practice to release my health information to the following parties in addition to my insurance carrier:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____ Date _____