.::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 __________________

____

Former Dentist ___________________________

City/ State ______________________________

Date of last dental visit __________________

Date of last x-rays _______________________

Place a mark on "yes" or "no" to indicate if you had any of the following:

Bad breath ❑ Yes ❑ No

Clicking or popping jaw ❑ Yes ❑ No

Chew on one side of the mouth ❑ Yes ❑ No

Cigarette, pipe, or cigar Smoking ❑ Yes ❑ No

Dry mouth ❑ Yes ❑ No

Fingernail biting ❑ Yes ❑ No

Food collection between the teeth ❑ Yes ❑ No

Foreign objects ❑ Yes ❑ No

Grinding teeth. ❑ Yes ❑ No

Mouth breathing ❑ Yes ❑ No

❑ Yes ❑ No

Mouth pain, brushing ❑ Yes ❑ No

❑ Yes ❑ No

Orthodontic treatment ❑ Yes ❑ No

Pain around ear ❑ Yes ❑ No

Periodontal treatment ❑ Yes ❑ No

Sensitivity to cold ❑ Yes ❑ No

Sensitivity to heat ❑ Yes ❑ No

Sensitivity to sweets

Sensitivity when biting ❑ Yes ❑ No

Bleeding gums	❑ Yes	❑ No	Gums swollen or tender	❑ Yes	❑ No	Sores or growths in your mouth	___
Blister on lips or mouth	❑ Yes	❑ No	Jaw pain or tiredness	❑ Yes	❑ No	How often do you floss?	___
Burning sensation on tongue	❑ Yes	❑ No	Lip or cheek biting	❑ Yes	❑ 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:

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

Medication:
____

Other :
____
_

Medications

List any medications you are currently taking and the correlating diagnosis:
____
_
____
_
Pharmacy Name ______________________________
Phone (______)______________________________

Allergies

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other ________________
  ____

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