Smiles ON MAIN

Patient Registration

Please take a few moments to answer the following questions so we can better assist you with your dental needs.

Patient Information

First Middle Last

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Sex: Male ____ Female ____ Social Security # _____

Email _____

Responsible Party Information (if under 21)

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Birthdate _____ Social Security # _____

Dental Insurance Information

Employer _____ Employer Address _____

Insured Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group # _____

Insurance Company Address _____

Insurance Co. Phone _____ Subscriber ID# _____ Birthdate _____

Do you have dual coverage? _____ **If yes, Please complete below**

Insured Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group # _____

Insurance Company Address _____

Insurance Co. Phone _____ Subscriber ID# _____ Birthdate _____

Emergency Information

In case of emergency, please contact: (someone outside of your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

(OVER)

Dental History

Former Dentist _____
City/State_____
Date of last visit _____
Date of last exam_____

Please circle all that apply:

Bad Breath
Bleeding Gums
Blisters on lips
Tobacco Usage
Clicking or popping jaw
Dry Mouth
Fingernail Biting
Grinding teeth
Gums swollen/tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth
Burning tongue
Orthodontic Treatment
Pain around ear
Periodontal Treatment
Sensitivity to hot/cold
Sensitivity to sweets
Sensitivity when biting
Sores in mouth
Growths in Mouth
Broken Fillings
How often do you floss? _____

Other Information (Please circle)

How did you decide to join our family of dental patients?

Personal Referral- _____ Phone Book Newspaper Internet Other _____

Consent for Treatment/Insurance Assignment/Financial Responsibility/Office Policies

1) I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of this patient's dental needs. I authorize the doctor, following appropriate diagnosis, to perform all recommended treatment mutually agreed upon by the patient, or representative of the patient, and the doctor.

2) I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of these risks.

3) I hereby authorize Smiles on Main to furnish information to insurance carriers concerning my dental needs and treatment, and I hereby assign to Smiles on Main all payments for services rendered to my dependents or myself. I understand that I am ultimately responsible for full payment of all charges, and Smiles on Main makes no guarantees of my insurance reimbursement. **Payment is expected from you at the time of service for *your part* of the charges. We accept cash, check, Visa, and Mastercard for your convenience.**

4) I understand that I am financially responsible for any and all unpaid amounts incurred in treatment. I understand that accounts that are 90 days past due are subject to a minimum service charge of $5.00 or 1.75% of the outstanding balance per month, whichever is greater.

5) I understand that if my account remains unpaid and is forwarded to a collection agency, I will be responsible for any reasonable collection costs, reasonable attorney fees and a $10.00 fee. I understand that if required, a check of my credit history may be made.

6) I understand that if required/necessary, a check of my credit history may be made.

7) I understand that in the event that my check is returned to Smiles on Main from the bank, I will be charged $30.00. I understand that I will be required to pay the amount of the original check plus the service fee within five business days by a cashier's check, money order, cash or credit card. If I fail to do this my account may be turned over to a collection agency.

8) I understand that a minimum of 24 hours notice is required for cancellation of appointments. A broken appointment fee may be charged to my account and is payable by me if a 24 hour notice is not given.

Your signature below indicates that all information is accurate and correct to the best of your knowledge and that you understand and accept these policies.

_____ _____ _____

Signature of parent or responsible party *Date* *Witness from Office*

Smiles ON MAIN

NAME:_____ DATE OF BIRTH:_____

MEDICATIONS

Instructions for Patients: Enter all of the prescriptions and over-the-counter medications you are currently taking. **Complete only the first four columns.**

Name of medication	Dosage	Times a day is it taken	What is it taken for?	FOR CLINIC USE ONLY	
				Entry date*	Discontinued**

MEDICAL UPDATES

FOR CLINIC USE ONLY

Medical updates: *Document any significant changes in medical status and/or medications.*

Date

SMILES ON MAIN HEALTH QUESTIONNAIRE

1. ARE YOU IN GOOD HEALTH? ..... Y N
   a. LAST PHYSICAL EXAM? _____
2. HAS THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR? ..... Y N
3. NAME OF PHYSICIAN? _____
4. ARE YOU NOW UNDER MEDICAL CARE? ..... Y N
   If so, please explain _____
   _____
5. HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION? ..... Y N
   If so, please explain _____
6. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
   a. Rheumatic Fever or Rheumatic Heart Disease ..... Y N
   b. Congenital Heart Disease? ..... Y N
   c. Cardiovascular Disease (Endocarditis, Heart Murmur, Heart Attack, Coronary Insufficiency, Coronary Occlusion, High Blood Pressure, Arteriosclerosis, Stroke, Mitral Valve Prolapse? ..... Y N
   d. Pacemaker/Defibrillator? ..... Y N
   e. Allergy or Hay Fever or Asthma? ..... Y N
   f. Hives or Skin Rash? ..... Y N
   g. Fainting Spells? ..... Y N
   h. Diabetes? ..... Y N
   i. Hepatitis, Jaundice or Liver Disease? ..... Y N
   j. Arthritis (Rheumatic or Osteo)? ..... Y N
   k. Ulcers (Stomach or Intestinal)? ..... Y N
   l. Kidney Trouble (Nephritis, Etc.)? ..... Y N
   m. Tuberculosis? ..... Y N
   n. Persistent Cough or Cough up Blood? ..... Y N
   o. Venereal Disease (Syphilis, Gonorrhea, Other)? ..... Y N
   p. Epilepsy or Seizure Disorder? ..... Y N
   q. Artificial Joint Prosthesis? ..... Y N
   r. Substance Abuse (Alcoholism, or Drug Addition Active or Recovering)? ..... Y N
   s. Immune System Depression? ..... Y N
   t. Organ Transplant? ..... Y N
   u. AIDS or HIV? ..... Y N
   v. Cancer? ..... Y N
   w. Chemotherapy/Radiation? ..... Y N
   x. Thyroid Disease? ..... Y N
   y. SLE (Lupus)? ..... Y N
   z. Steroid Therapy? ..... Y N
7. DO YOU HAVE PAIN IN CHEST UPON EXERTION? ..... Y N
8. SHORT OF BREATH AFTER MILD EXERCISE? ..... Y N
9. DO YOUR ANKLES SWELL? ..... Y N
10. DO YOU GET SHORT OF BREATH WHEN YOU LIE DOWN, OR DO YOU REQUIRE EXTRA PILLOWS TO SLEEP? ..... Y N
11. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS SURGERY, EXTRACTIONS OR ACCIDENTS? ..... Y N
12. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? .. Y N
13. DO YOU HAVE ANY BLOOD OR BLEEDING DISORDERS (ANEMIA, ABNORMAL PLATELET FUNCTION, ETC.)? Y N
14. HAVE YOU EVER HAD SURGERY OR X-RAY TREATMENT FOR A TUMOR, GROWTH OR OTHER CONDITION? ..... Y N
15. ARE YOU TAKING ANY OF THE FOLLOWING?
   a. Antibiotics or Antirival Medicine? ..... Y N
   b. Anticoagulants (Blood Thinner)? ..... Y N
   c. Medicine for High Blood Pressure? ..... Y N
   d. Cortisone or Steroids? ..... Y N
   e. Nervous System Medicine (Antidepressants, Antipsychotics, Anti-anxiety)? ..... Y N
   f. Asthma or Respiratory Medicines? ..... Y N
   g. Aspirin or Anti-inflammatory Agent? ..... Y N
   h. Dilantin or other Seizure Medicine? ..... Y N
   i. Antidiabetic Medicine (Insulin, Micronase, Etc.)? .. Y N
   j. Digoxin or Drugs for Heart? ..... Y N
   k. Nitroglycerin? ..... Y N
   l. Narcotic Analgesic? ..... Y N
   m. Birth Control "Pill"? ..... Y N
   n. Antabuse? ..... Y N
   o. Recreational Drugs or Substances? ..... Y N
   p. Do you regularly take herbal medicine or dietary supplements? ..... Y N
   Circle all that apply:
   • Echinacea • Garlic • Ginger • Kava
   • Feverfew • Ginko • Ginseng
   • Valerian • Vitamin E • St. Johns Wart
   q. Any other (Prescription or Over-the-counter)? ..... Y N
16. DO YOU USE SMOKELESS TOBACCO? ..... Y N
17. ARE YOU ALLERGIC TO OR REACTED ADVERSELY TO ANY OF THE FOLLOWING?
   a. Local Anesthetics? ..... Y N
   b. Penicillin or other Antibiotics? ..... Y N
   c. Aspirin or other Anti-inflammatory Drugs? ..... Y N
   d. Barbiturates, Sedatives, or Sleeping Pills? ..... Y N
   e. Narcotic Analgesics? ..... Y N
   f. Anti-anxiety or Muscle Relaxant Medicines? ..... Y N
   g. Latex (Rubber Gloves, Etc.)? ..... Y N
   h. Any other? ..... Y N
18. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY OTHER PREVIOUS DENTAL TREATMENT? Y N
   If so, please explain _____
   _____
19. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? ..... Y N
   If so, please explain _____
   _____

WOMEN

20. ARE YOU PREGNANT? ..... Y N

_____
The undersigned agrees that the information above is accurate

_____
Signature Date