



Patient Registration

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

Patient Information

Name _____ Date _____
First Middle Last
 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 _____

Dental History

Former Dentist _____
City/State _____
Date of last visit _____
Date of last exam _____

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? _____

Please circle all that apply:

Bad Breath
Bleeding Gums
Blisters on lips

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

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 _____