PLEASE PRINT

Smiles by Design

PATIENT REGISTRATION

Patient Name____ Birthdate______________ Age_______
(First) (Middle) (Last) (Preferred)

SS#__________________ DL#______________ Employer__________________ Work #(____)__________

Marital Status: Single___Married___Divorced___Widowed___Spouses Name:__________________ Work #(____)__________

Home Address:____ Zip______________

Home #: (____)__________Cell #: (____)__________ E-Mail Address:__________________________

Responsible for Insurance/Account:______________________ Relationship:______________________

SSN__________________DOB______________ Home # (____)__________________

Home Address (if different):____________________________________ Zip______________

Employer & Address:____Work #: (____)__________

Nearest Relative Not Living With You____________________________Phone # (____)__________

Who told you about us?__________________________Physician:__________________________

Do you have Dental Insurance? YES/NO With Whom?__________________________________

Do you have secondary insurance? YES/NO With Whom?__________________________________

Are you currently having dental problems? YES/NO What are your concerns? *circle as many as applicable (*Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Cleaning)(Wasting/Exceeding Dental Ins. Limits) (General Health) (Routine Checkup) (Other)____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? Name?........ YES NO
2. Have you ever had high blood pressure?........ YES NO
3. Has a physician ever said you had heart trouble?........ YES NO
4. Do you have artificial joints?........ YES NO
5. Have you ever had abnormal bleeding following a cut or extraction?........ YES NO
6. Has a physician or dentist ever said you had a tumor or cancer?........ YES NO
7. Are you allergic to Penicillin, Novocain, Codeine or any other medicine?........ YES NO
   If so, what?____
8. Are you allergic to anything other than medicine? (e.g. latex or metals)?........ YES NO
   If so, what?____

Do you have or ever had:

1. Radiation treatment........ Yes No
2. Heart Disease/Pacemaker........ Yes No
3. Anemia/leukemia/low platelets........ Yes No
4. Epilepsy/seizures........ Yes No
5. Asthma/hay fever........ Yes No
6. Tuberculosis........ Yes No
7. Diabetes/How long?_______........ Yes No
8. Kidney trouble........ Yes No
9. Liver trouble/jaundice........ Yes No
10. Thyroid trouble/goiter........ Yes No
11. Fainting/dizziness........ Yes No
12. Glaucoma........ Yes No
13. Arthritis........ Yes No
14. HIV/AIDS/syphilis/VD/hepatitis........ Yes No
15. Stroke........ Yes No
16. Stomach ulcer........ Yes No
17. Heart murmur........ Yes No
18. Eczema/hives........ Yes No
19. Psychiatric treatment........ Yes No
20. Are you pregnant?........ Yes No

Are you now taking:

1. Fosamax/Boniva/Actonel........ Yes No
2. Drugs for high blood pressure........ Yes No
3. Drugs for sleep........ Yes No
4. Cortisone/steroids/ACTH........ Yes No
5. Anticoagulants/blood thinner/aspirin........ Yes No
6. Tranquilizers/sedatives........ Yes No
7. Antibiotics........ Yes No
8. Insulin........ Yes No
9. Please list any medications you are taking (RX or otherwise):

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Pharmacy: ______________________________

I Understand That Payment Is Due At Time Of Service.
I will pay today by: CASH ❑ CHECK ❑ CREDIT CARD ❑

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Smiles by Design to discuss my conditions with my physician(s) and to request medical information from them. I authorize Smiles by Design to obtain and verify a credit report. I also acknowledge that I have been given or offered a copy of the office's "Notice of Privacy Practices".

Signature______________________**Date**__________
Signature______________________**Date**__________
Signature______________________**Date**__________
Signature______________________**Date**__________

Treatment Organizer

Preferred Name____________________ **Spouse**____________________ **Date**_______________

Family____ **Email or Text?** ☐ **Yes** ☐ **No**

Units / Prod.	Order / Rm #	Description	Date / Time	
				Est. __________ **Date** __________ **Est. Ins.** __________ **Ded** __________ **Est. Pt.** __________ **Sig.** __________
				Est. __________ **Date** __________ **Est. Ins.** __________ **Ded** __________ **Est. Pt.** __________ **Sig.** __________
				Est. __________ **Date** __________ **Est. Ins.** __________ **Ded** __________ **Est. Pt.** __________ **Sig.** __________
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				Est. __________ **Date** __________ **Est. Ins.** __________ **Ded** __________ **Est. Pt.** __________ **Sig.** __________

The totals and subtotals above are **ESTIMATES** for treatment that is known. These totals and subtotals would not include any other treatment or service that is not listed above. Other treatment or service may become necessary due to circumstances or treatment not considered at this time. The cost of the treatment or service is always the responsibility of the patient.

Signature:______________________________ **Date:** _______________

Notes ____

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