Welcome

The benefits of a healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out the form completely. The more we know about you, the better we can care for you.

About You

Today's Date_____ E-mail Address _____

Referred by _____

Name:_____ I prefer to be called _____
Last first MI

Birthdate ____/____/____ Age ____ Social Security # _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

☐ Male ☐ Female Drivers License #_____

Home Address: _____
Street City State Zip

Home Ph. # (____)_____ Pager /Car # (____)_____ Work # (____)_____

Where and when are the best times to reach you?_____

Employer: _____ How long there?_____Occupation_____

Employer's address _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His/Her Name _____ Relation _____Work # (____)_____Home # (____)_____

Address: _____
Street City State Zip

Spouse or Parent Information

His/Her Name: _____ Birthdate ____/____/____ Social Security # _____

Employer: _____ Work # (____)_____ Ext_____Drivers Lic. _____

Insurance Information

Primary Insurance _____ Phone (____)_____ Group (Policy) # _____

Address: _____
Street City State Zip

Insured's Name: _____S.S. # _____ Insured Birthdate ___/___/___ Relation_____

Insured Employer _____Employers Address _____
Street City State Zip

Secondary Insurance_____Phone(____)_____ Group (Policy) # _____

Address: _____
Street City State Zip

Insured's Name: _____S.S. # _____ Insured Birthdate ___/___/___ Relation_____

Insured Employer _____Employers Address _____
Street City State Zip

CIRCLE ONE

1. Are you having pain or discomfort at this time?.....YES NO
2. Do you feel very nervous about having dental treatment?.....YES NO
3. Have you ever had a bad experience in the dental office?..... YES NO
4. Have you been a patient in the hospital during the past two years?.....YES NO
5. Have you been under the care of a medical doctor during the past two years?.....YES NO

Physician's Name_____Phone #_____

Address_____

6. Have you taken any medicine or drugs during the past two years?.....YES NO
7. Are you now taking any medication , drugs or pills?.....YES NO

If yes, please list:_____

8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance..... .....YES NO

If yes, please list:_____

9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

YES NO Heart Failure	YES NO Emphysema	YES NO Hepatitis A (infectious)
YES NO Heart Disease	YES NO Cough	YES NO Hepatitis B (serum)
YES NO Angina Pectoris	YES NO Tuberculosis (TB)	YES NO Liver Disease
YES NO High Blood Pressure	YES NO Asthma	YES NO Yellow Jaundice
YES NO Heart Murmur	YES NO Hay Fever	YES NO Blood Transfusion
YES NO Rheumatic Fever	YES NO Sinus Trouble	YES NO Drug Addiction
YES NO Mitral Valve Prolapse	YES NO Allergies or Hives	YES NO Hemophilia
YES NO Scarlet Fever	YES NO Diabetes	YES NO Venereal Disease
YES NO Artificial Heart Valve	YES NO Thyroid Disease	(Syphilis, Gonorrhea)
YES NO Heart Pacemaker	YES NO X-Ray or Cobalt treatment	YES NO Cold sores
YES NO Heart Surgery	YES NO Chemotherapy	YES NO Fever Blisters
YES NO Artificial Joints	YES NO Arthritis	YES NO Epilepsy or Seizures
YES NO Anemia	YES NO Rheumatism	YES NO Fainting or dizzy spells
YES NO Stroke	YES NO Cortisone Medicine	YES NO Nervousness
YES NO Kidney Trouble	YES NO Glaucoma	YES NO Psychiatric Treatment
YES NO Ulcers	YES NO Pain in Jaw Joints	YES NO Sickle Cell Disease
YES NO Cosmetic Surgery	YES NO HIV+	YES NO Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
11. Do your ankles swell during the day ? YES NO
12. Do you use more than 2 pillows to sleep? YES NO
13. Have you lost or gained more than 10 pounds in the past year? YES NO
14. Do you ever wake up from sleep short of breath? YES NO
15. Are you on a special diet? YES NO
16. Has your medical doctor ever said you have a cancer tumor? YES NO
17. Do you have any disease, condition, or problem not listed? YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐Yes ☐No If yes, what month?_____Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless financial arrangements gave been made, and that fees may be accessed for missed appointments without 24 hours notice.. I further understand that a finance charge (18% annually) will be added to any balance over 60 days in the event of default I(We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____Date_____

Parent or Responsible Party_____

Relationship to Patient_____

CONSENT TO TREATMENT

The undersigned acknowledges that he\she has requested dental services from Smiles by Design P.C., and authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated.
Any therapy suggested to you can, of course, be refused and \ or terminated at any time and you are never under any obligation to complete any therapeutic recommendations.

DISCLOSURE OF INFORMATION

All information provided to Smiles by Design P.C. staff and clinicians is strictly confidential except for the following:

1. Your insurance company request information about your treatment in order to process a claim or certify care
2. The patient authorizes the release of information by signing a release form naming the specific person to the information.
3. Certain circumstances where we are required by law to release patient information (e.g. court subpoena, suspected abuse, etc.)

FINANCIAL TERMS

You are expected to pay for your care as the services are rendered. However, if you plan on using insurance to cover part or all of your treatment, we will contact your insurance company to verify your eligibility and available benefits. Your insurer ultimately determines coverage at the time a claim is filed. We cannot, therefore, guarantee coverage and\or payment by your carrier. If carrier denies payment for any reason, you will be 100% responsible for the amount owed to Smiles by Design P.C. Patients covered by insurance are expected to pay applicable co-payment and \or deductibles at the time services are rendered. If we have not received reimbursement from your insurance company within 90 days, you may be billed for this amount and will have to seek reimbursement directly from your carrier.

CANCELED \ MISSED APPOINTMENTS & LATE ARRIVAL

We recognize the importance of your time, and strive to stay on time. When you make an appointment, we are reserving time that is no longer available to other patients. If you need to cancel an appointment, we ask that you cancel your appointment at least 24 hrs in advance. The office's voicemail (312) 263-2323 accepts messages about appointment cancellations at any time (24hrs \ day). Patients who miss appointments without providing at least 24 hours notice may be charged a missed office visit of $50.00. Similarly, late arrivals can create scheduling problems with other patients. If you must be late, please call us to let us know. If you arrive more than (15) minute late, we may not be able to honor your appointment unless the clinician has an open appointment directly following your scheduled time and can accommodate your appointment without interfering with scheduled times of other patients. Patients that arrive more than (30) minutes late without notice, may be charged a missed appointment fee of $50.00

ACKNOWLEDGEMENT AND AGREEMENT

I have read the above information and thoroughly acknowledge, understand and agree all of the above information, including financial terms as stated above.

_____ _____

Patient, Parent of Guardian – Name Printed Patient, Parent or Guardian – Name Signature

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