

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____ Birth Date: _____
 Social Security #: _____ Phone (Home): _____
 Phone (Work): _____ Cell _____ Best time to call: _____
 Email Address: _____
 Address: _____
Street Apartment #
City State Zip Code
 How did you hear about our office? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

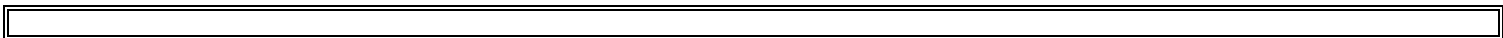
- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Please list any medications that you are currently taking. _____

- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

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.

Signature of patient, parent or guardian _____ Date: _____



Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

I understand that it is ultimately my responsibility to inform the doctor of any changes in my medical history including new prescription medication and pregnancy.

As a condition of your treatment by this office, financial arrangements 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 at the time services are performed.

As a courtesy, Elite Smiles will file insurance claims; handle insurance inquiries, process follow-ups, and follow-up on lost claims. In the event that the insurance company does not reimburse Elite Smiles, with in 60 days or reimburses at a lower rate than estimated, the patient will be responsible for the unpaid insurance portion. The patient will have 90 days to settle the account before the account is turned over to collections. If the insurance company reimburses at a higher rate than estimated, Elite Smiles will credit the patients account.

I understand that the insurance coverage quoted by Elite Smiles is only an estimate. Elite Smiles can not guarantee the exact amount covered by the insurance company. I understand that the treatment plan and fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services 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 his 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 also grant my permission to you or your assignee to share any necessary information with my insurance company for billing purposes.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party