WELCOME!

CONTACT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev	Please Print: Last,	First,	Middle
☐ Female ☐ Male ☐ Other	Date of Birth / /	Social Security #	Email Address

Mailing/Billing Address	Apt/Unit	City	State	Zip

Alternate/Permanent Address (if different than above)

Cell Phone # ( )	Home Phone # ( )	Work Phone ( )	Ext.

How did you hear about Smart Dental?	Occupation	Preferred Name

ALTERNATE/EMERGENCY CONTACT INFORMATION

Please Print: Last,	First	Relationship to patient

Cell Phone # ( )	Home Phone # ( )	Work Phone ( )	Ext.

INSURANCE/POLICY HOLDER INFORMATION (if different than above)

Legal Name: Last,	First,	Middle	Date of Birth / /	Relationship to patient

Policy Holder Permanent Address	City	State	Zip	Policy Holder Preferred Phone # ( )

Insurance Company	Phone Number	Employer

Subscriber/Member ID Number	Group Number	Policy Holder Social Security #

WELCOME! We are delighted to welcome you as a patient at Smart Dental and want to ensure we meet your expectations and communicate openly our expectations of all of our patients.

Consent to Treatment: The undersigned consents to x-ray examinations, laboratory procedures, anesthesia, diagnostic tests, dental treatment, or other procedures that may be recommended by Smart Dental. Although the undersigned may elect not to undergo certain specific procedures, we may decline to treat you without adequate diagnosis or treatment plan.

Financial Agreement: The undersigned understands that responsibility for payment for dental services provided at Smart Dental for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance in writing. For accounts that are more than 60 days past-due, a 1.5% late fee may be applied every month (18% per annum). Should an account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Authorization and Assignment of Benefits: The undersigned authorizes Smart Dental, LLC to submit claims (on the patient's behalf) to insurance or other third party payor(s) and to disclose health information to the extent necessary to obtain payment. The undersigned also assigns and authorizes benefits paid by insurance or other third party payor(s) directly to Smart Dental, LLC. Smart Dental will process dental insurance as a convenience to our patients. Smart Dental will make every effort to estimate dental insurance coverage or benefits; however, any claims or balances left unpaid after 45 days will become the patient's responsibility and become due immediately.

Missed Appointments: I understand that my appointment times are reserved exclusively for me. I understand that if I miss an appointment without notification or change an appointment time with less than 48 hours notification I may be charged a minimum $35.00 broken appointment fee.

Health Information Disclosure: The undersigned has received Smart Dental, LLC's Notice of Privacy Practices and consents to the use and disclosure of their health information to carry out treatment, payment activities and health care operations. You have a right to revoke this consent at any time by giving us written notice. However, we may decline to treat you if you revoke this consent.

Patient Representative ____________ Date ____________

Patient Signature ____________ Date ____________

Relationship to Patient ____________

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HEALTH HISTORY

SMART DENTAL

PATIENT NAME:_______________________________

DATE:__________

PLEASE ANSWER EACH QUESTION **CIRCLE ONE**

1. Have you been a patient in a **hospital** during the past 5 years .... Yes No
2. Have you been under the care of a physician during the past 5 years?. .... Yes No
3. Are you under the care of a physician now? .... Yes No

Name of Physician: _______________________________

Name and Address of Medical Facility: _______________________________

Date of Last Medical Examination: _______________________________

4. Have you taken **any kind of medication** or drugs during the past two years? .... Yes No
   Have you ever taken any type of **blood thinner** (e.g. Warfarin, Plavix)? .... Yes No
   Have you ever taken any type of **steroid medication?** .... Yes No
   Have you ever taken, or are you currently taking any **medications to increase bone density** or prevent bone destruction for osteoporosis or cancer (e.g. Fosamax, Actonel, Aredia, Zometa) .... Yes No

5. **Please list all medications,** drugs, herbal remedies, recreational, over-the-counter medications, birth-control pills and vitamins taken in the past 2 years:

6. Are you **allergic** or have you ever reacted adversely to any of the following medications?

   Latex   Antibiotics (e.g. Penicillin)   Pain Medications   Local Anesthetics   Anxiety Medications
   Please Explain:

7. Are you allergic to any other medications or substance? .... Yes No
   If yes, please list all: _______________________________

8. Have you ever had any excessive bleeding requiring special treatment? .... Yes No
9. (WOMEN) Are you pregnant now or is there a chance that you are pregnant? .... Yes No

10. **Please circle** any of the following, which you have had or have presently:

Heart trouble	Asthma/Emphysema	Chemotherapy	Ulcers/Colitis	Congenital heart lesions
Tuberculosis (TB)	Sinus trouble	Dehydration	High blood pressure	Persistent Cough
Immune Disorder	Fainting	Rheumatic fever	Anemia	Radiation Therapy
Alcohol Dependence	Artificial heart valve	Bleeding Disorder	Epilepsy/Seizures	Substance Abuse
Heart pacemaker	Bruise easily	Arthritis	Depression/Anxiety	Stroke
Diabetes	Osteoporosis	Psychiatric Treatment	Heart Attack	Hepatitis/Jaundice
Artificial joints	Cancer/Tumor/Cyst	Difficulty breathing	Thyroid Disease	Gastrointestinal Disorder

11. **Please list any other illnesses, infections, diseases or conditions not listed above.**

12. Please list all **surgeries** and dates.

13. Have you ever smoked or used **tobacco** products in the past? .... Yes No
14. Do you currently smoke or use **tobacco** products? .... Yes No

Please indicate **any special needs or concerns.** Also, please list anything else you think we should know about you or your health.

____
Patient Representative Date

_______________________________ _______________________________
Patient Signature Date Relationship to Patient

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