PATIENT REGISTRATION

Today's Date_____ **(PLEASE PRINT)**

Name_____Home Phone_____
Address_____City_____State_____Zip_____
Sex M F Age_____Birthdate_____ Minor Single Married Divorced Widowed Separated
Email Address_____**Cell Phone**_____
Employer_____ Business Phone_____
Social Security #_____Spouse/Parent's Social Security#_____
Name of Spouse_____Spouse's Birthdate_____
Person responsible for this account_____Relationship to patient_____
Insurance Company_____Subscriber ID_____Phone_____
In case of emergency, who should we contact? _____Phone_____
Whom may we thank for referring you?_____

MEDICAL / DENTAL HISTORY

What is your immediate dental concern?_____
Name of former dentist_____Date of last dental visit_____
Physician's name_____Phone_____Date of last visit_____

Have you ever had any of the following? **(PLEASE CHECK EACH BOX) Thank you!**

Yes	No		Yes	No		Yes	No	
__	__	AIDS/HIV	__	__	Circulatory Problems	__	__	Nervous Problems
__	__	Alcohol Use	__	__	Diabetes	__	__	Pacemaker
__	__	Allergies to Medicine or Drugs	__	__	Emphysema	__	__	Psychiatric care
__	__	Anemia	__	__	Epilepsy	__	__	Radiation Treatment
__	__	Anticoagulants(Blood Thinners)	__	__	General Allergies	__	__	Recent Weight Loss
__	__	Arthritis	__	__	Headaches	__	__	Respiratory Disease
__	__	Artificial Joint or Heart Valves	__	__	Heart Murmur	__	__	Rheumatic Fever
__	__	Asthma	__	__	Hemophilia	__	__	Sinus Problems
__	__	Back Problems	__	__	Hepatitis, Jaundice or Liver Disease	__	__	Stroke
__	__	Blood Disease	__	__	High Blood Pressure	__	__	Tobacco Use
__	__	Cancer	__	__	Kidney Disease	__	__	Thyroid
__	__	Chemical Dependency	__	__	Latex Sensitivity	__	__	Tuberculosis
__	__	Chronic Diarrhea	__	__	Mitral Valve Prolapse	__	__	Ulcer

Any History of Drug use?_____
Do you have any drug allergy or have had an adverse reaction to any medication?_____If yes, What_____
_____
Have you ever responded adversely to medical or dental treatment?_____
Are you currently taking any medication?_____If yes, What_____
_____
Are you under the care of a physician?_____For what conditions?_____
_____
If patient is a child, what is his/her weight?_____
(WOMEN ONLY)Do you suspect that you are pregnant? Yes No Are you taking birth control medication? Yes No
Is there anything else we should know about your medication history?_____

ACKNOWLEDGMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing or processing of insurance for benefits for which I am entitled. I will not hold Smile Concepts and its owners, agents, and/or employees responsible for any errors or omissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT TIME OF SERVICE. In the event of default of payment, my account may be turned over to the collection agency and I will be liable for all late fees, court costs, attorney fees and/or collection fees incurred.

Signature of Responsible Party_____**Date**_____
PATIENT, PARENT OR AGENT MUST BE 18 YEARS OR OLDER