Ultimate Smile Dental P.C

Patient Information

Name: _____
First Last Gender Marital Status

Home Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: (___) _____ - _____ Home Phone #: (_____) _____ - _____
Email: _____ Date of Birth: ___/___/_____ SSN: _____
If patient is a minor, name of parent(s): _____
Employer: _____ Occupation: _____

How did you hear about us? _____

RESPONSIBLE PARTY

Name of Person Responsible for Account Payment (if not yourself): _____
Cell Phone #: (_____) _____ - _____ Relationship: _____

INSURANCE INFORMATION
(Provide Insurance Card)

Primary Dental Insurance: _____ Member ID #: _____ Group #: _____
Subscriber's Full Name: _____ SSN: _____ Relation: _____
Date of Birth: _____ Employer: _____ Occupation: _____

Secondary Dental Insurance: _____ Member ID #: _____ Group #: _____
Subscriber's Full Name: _____ SSN: _____ Relation: _____
Date of Birth: _____ Employer: _____ Occupation: _____

MEDICAL HEALTH HISTORY

Please **CIRCLE** all that apply

Chest pain, shortness of breath Bleeding problems, bruise easily Headaches, ringing in ears
High cholesterol Fainting or seizures or Epilepsy Heart murmur, rheumatic fever
Mitral valve prolapse Tumor, cancer, radiation treatment Blood disorder, transfusion High Blood Pressure Heparin, Coumadin, blood thinners anticoagulants Cortisone, steroids
Kidney or Bladder problems Psychiatric care, Anxiety, Depression Nitroglycerin, Hepatitis, Cirrhosis, Jaundice
Asthma, pneumonia or lung disease Heart disease or heart attack
Diabetes Type 1 or Type 2 AIDS or HIV positive Joint pain, stiffness or arthritis
Tobacco use or Smoking Thyroid problems, GERD, Acid reflux Dementia, Parkinson's
Others_____

Are you required to pre-medicate before any dental treatment? Y or N
If yes, name the medication taken: _____
Are you allergic or reacted adversely to anything? If so, please list. _____
Are you pregnant or attempting to get pregnant? Y or N

Primary Physician's Name: _____ Phone number: (_____) _____ - _____

Please list all prescription, over-the-counter medications or vitamins you're currently taking: _____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand it's very important to report any changes in my medical or dental status to the dentist at the earliest time, and I agree to do so.

Signature: _____ Date: ___/_____/_____

Back Page

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CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required ensuring proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. I agree to be responsible for all payment of all services rendered on my behalf and that my dependents. I understand that payment is due at the time of service unless other arrangement have been made. In the event payments are not received by agreed upon dates, I understand that I am responsible for any legal fees including but not limited to court and lawyer fees.

5. I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at **least 24 hours** prior to the appointment, so that another patient may use my time. I understand that if I fail to notify the office in advance, I will be charged **a fee of $50** for each scheduled hour.

Print name: _____

Signature (Responsible party): _____ Date: ____/____/____

Relationship to patient: _____

NOTICE OF HIPPA PRIVACY PRACTICES

I have reviewed Ultimate Smile Dental, PC Notice of Privacy Practices

Print name: _____

Signature (Responsible party): _____ Date: ____/____/____

Relationship to patient: _____

FINANCIAL POLICY

I understand that dental insurance is a contracted benefit between my employer, the insurance carrier, and myself and at no time is the insurance carrier obligated to pay benefits to the practice. I understand that I am responsible for the entire balance of my account regardless of expected or implied insurance benefits, I understand that as a courtesy, my dentist will process treatment claims.

Print name: _____

Signature (Responsible party): _____ Date: ____/____/____

Relationship to patient: _____