



Guest Registration

Today's Date: _____ E-Mail Address: _____

Name: _____ Male Female
Last First Initial Preferred Name

Birth date: _____ Age: _____ Single Married Divorced Separated Widowed

Home Address: _____ Social Security #: _____
No. Street City State Zip

Home Phone #: _____ Mobile #: _____ Work #: _____

Employed By: _____ Occupation: _____

Business Address: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone #: _____

Dental Insurance

We accept most dental insurance plans. As a courtesy to our guests we will happily submit claims to your carriers and assist you in understanding your benefits. Please be aware that your insurance carrier is responsible to you, as you are responsible to us. No one at this office is authorized to guarantee your coverage or benefits, as we are not agents for your insurance carrier. In order to provide quality care, we must be able to treat our guests without regard for insurance or the limitations they establish. We can only "guesstimate" what your insurance plan pays for services rendered. Please keep in mind that you are responsible for your account.

Name of Dental Insurance Company: _____ Group name and #: _____

Subscriber's name: _____ Subscriber's ID #: _____

Relationship to patient: _____ Birth date: _____ Social Security #: _____

Is patient covered by additional insurance? _____, if yes:

Name of Dental Insurance Company: _____ Group name and #: _____

Subscriber's name: _____ Subscriber's ID #: _____

Relationship to patient: _____ Birth date: _____ Social Security #: _____



Financial Policy

Thank you for choosing us to care for your dental health! We look forward to caring for your smile and are committed to your successful treatment. We do this by providing the same high quality care for you that we would for ourselves and our closest relatives.

Please understand that payment for your services is considered part of your treatment. We accept most forms of payments: MasterCard, VISA, Discover, American Express, ATM Cards, Cash and easy payment programs through third party sources, such as Care Credit and Unicorn. We will be happy to assist you in establishing an account with a third party source.

Our goal is also to keep costs as low as possible, which means that we are unable to bill our guests for services. It is our policy to take down credit card numbers for optimal billing of our patients. We hope this will decrease the bills you receive, the checks you must write, and the stamps that must be licked. We will therefore charge a credit card for those charges that are the remaining balance after insurance payments, balances from co-pays, deductibles, and/or denials from your insurance company. If there is any overpayment, any and all appropriate charges will be refunded back to your credit card. This information will be stored with your other confidential medical and dental records.

Guest Name: _____

Credit card type and number: _____

Exp. Date: (MM/YY): _____ CVC # (from the back of the card): _____

Billing Address: _____
No. Street City State Zip

Verified by: (Office Personnel) _____

Appointment Policy

We have your interest at heart, and want you to be completely happy and satisfied with the high quality of your dental care and with the sincere and frank discussion of our appointment policy.

Many patients who are used to the “*clinic*” type practice are surprised to find that we are usually on time. Instead of scheduling multiple patients to a single time, we reserve your appointment especially for you. Due to such personalized time, it is impossible to see late patients. This is because the doctor’s time is **RESERVED** for each and every patient.

We have found that most patients respect our time as much as we respect theirs. When an appointment is missed for any reason (even good ones), our late/cancellation/failed appointment policy will apply.

We require at least a 24 hour business day notice for changed appointments, or there is a **\$75.00 fee for every hour** of scheduled appointment. This allows us to schedule another patient and time is not completely lost. Thank you for your cooperation.

I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

Guest Signature: _____ Date: _____

Medical History

Physician's Name and Phone #: _____ Date of last physical: _____

Have you ever had any of the following? (Check boxes that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Hepatitis, Jaundice or
Liver Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Blood Disease | | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis (TB) |

Please list any serious medical condition(s) that you have experienced: _____

Please list any medications and/or over-the-counter drugs that you are taking: _____

Are you allergic to any of the following? (Check boxes that apply)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Jewelry/Metals	<input type="checkbox"/> Latex	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Anesthetics	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Other

Have you ever responded adversely to medical or dental treatment? (Explain) _____

Are you currently under care of a physician? Yes No For what condition? _____

- (Women) 1. Do you suspect that you are pregnant? Yes No 2. Are you nursing? Yes No
3. Are you taking birth control pills? Yes No (**Warning:** Birth control pills are less effective while taking antibiotics)

Dental History

Reason for today's visit: _____

Are you happy with the way your smile looks? Yes No, What would you change? _____

Would you like 1. Straighter teeth? Yes No 2. Whiter Teeth? Yes No 3. Fresher breath? Yes No

Many of our guests consult us for a second opinion, have you seen another dentist for your dental needs? Yes No

If you are missing teeth, would you be interested in knowing more about implant or other options? Yes No

- | | |
|---|--|
| Are you currently in pain? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you require antibiotics before dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Your current dental health is <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | Do you have mobility in your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you brush daily? <input type="checkbox"/> Yes <input type="checkbox"/> No | Type of bristles on your toothbrush? <input type="checkbox"/> Hard <input type="checkbox"/> Medium <input type="checkbox"/> Soft |
| Do your gums bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had periodontal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any neck, head, or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are your teeth sensitive to heat, cold, or anything else? (Explain) _____ | |

Authorization

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or my medication changes, I will inform the doctor at my next appointment without fail. By signing this form I consent to dental treatment provided by the Smile Designers Team; explained by them at this or subsequent appointments. I understand this may include the administration of drugs, complications from which may last beyond the duration of the drug. I recognize that failure may occur for various reasons and that complications can occur with any procedure. I understand and am purchasing a service, not a product, and therefore cannot be guaranteed or warranted. I understand I can ask questions at any time.

Full Name: _____ Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

Please read the “privacy and dental material” sheet form (PDF format) first.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birth date: _____

Signature: _____ Date: _____

DENTAL MATERIAL FACTS ACKNOWLEDGEMENT

I have received the Dental Material Facts and I have been provided an opportunity to review it.

Name: _____ Birth date: _____

Signature: _____ Date: _____