Smile Design

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Date: ___________________________

Patient Information

First name: __________________________ Middle Initial: _____ Last name: ___________________

Address: ____

City: ______________________ ST: ______ ZIP: ______________

Home phone: _______________________ Cell: ____________________ Work: _______________

Email: ____

Birth date: ___________________ SSN: ___________________________

Employer: ____

Emergency Contact: ____ Phone: ______________

Referred by: [] Google [] Website [] Insurance [] Drove by

[] Another dentist: _____________________ Family/Friend: ________________________________

Parent/Guardian Information (if patient is under 18)

Parent/Guardian's first name: _________________ Parent/Guardian Last name: __________________

Address: ____

City: ____________________ ST: _______ ZIP: ____________

Home phone: ____________________ Cell phone: _______________ Work phone: _____________

Relationship to patient: __________________________ Current patient: [] yes [] no

Employer: ____________________________________

Primary Dental Insurance

Insurance company name: ________________________________

Name of policy holder: _______________________________ Relationship to patient: ____________

Birth date: ____________________ SSN or ID number on card: ______________________________

Secondary Dental Insurance

Insurance company name: ________________________________

Name of policy holder: _______________________________ Relationship to patient: ____________

Birth date: ____________________ SSN or ID number on card: ______________________________

Health History

List all prescription drugs and non-prescription drugs you are taking**: (We can make a copy if you have a list)**
____
____
List any allergies to medications or contact allergies **(latex)** and the reaction: ________________________________
____
Please list any operations you have had and the year: ____
____
Are you under a specialist care? (example heart doctor): [] yes [] no
If yes, please list the specialist's name: ______________________________ Phone: _________________________
What are you being treated for: ____

Women only:

Are you pregnant? [] yes [] no If yes, how many weeks? _______________
Are you nursing? [] yes [] no

Medical Conditions:

[] heart disease
[] heart attack
[] heart murmur
[] artificial heart valves
[] chest pain
[] rheumatic fever
[] high blood pressure
[] low blood pressure
[] stroke
[] asthma
[] breathing problems
[] Hepatitis A
[] Hepatitis B
[] Hepatitis C
[] HIV/AIDS
[] TMJ or jaw problems
[] joint replacement
[] fainting
[] unusual bleeding
[] excessive bleeding
[] diabetes Type 1 or 2? ____
[] seizures
[] cancer
[] radiation/chemo treatment
[] thyroid problems
[] phycological disorder
[] Tuberculosis
[] sinus problems
[] sleep apnea
[] Scarlet fever
[] respiratory problems
[] pacemaker
[] mitral value prolapse
[] kidney disease
[] liver disease

Dental History

What are your concerns for today's visit? ____
Do you have any of the following or had in the past?
[] braces
[] periodontal treatment
[] dentures
[] partials
Name of previous dentist: ____________________________ Last seen: ___________________________________
Reason for leaving: ____

Authorization for Release of Information/Assignment of Benefits/Responsibility of Charges:

I certify that the above information is true and correct. I authorize Smile Design/Marc L. Susman, D.D.S. to furnish information to my insurance concerning my conditions and/or treatment. I further agree for all payments on behalf of myself or my dependents for services rendered, be assigned to Smile Design/Marc L. Susman, D.D.S. I also understand I am responsible for any portions not covered by insurance as that is a contract between myself and the insurance company.

Missed Appointment and Short Notice Cancellation Policy:

There will be a $50 per hour charge for any no show/no call appointment. All appointment not cancelled within 24 hours of scheduled time will also be charged.

____ ________________________________

Signature of patient (parent/guard if under 18) **Date**