Smiles of Michigan

TODAY'S DATE:_____

Welcome
Our staff looks forward to providing you the best in dental care. Please ask if you have any questions.

1 PATIENT INFORMATION

Name:_____

Name Preferred:_____Birthday:_____

Mailing Address:_____Apt#_____

City:_____ State_____ Zip_____

SSN:_____

PREFERRED CONTACT

☐ Home:_____
☐ Work :_____
☐ Cell :_____
☐ EMail :_____

STATUS: ☐ Minor ☐ Single ☐ Married ☐ Other

In Case of Emergency Contact:_____

Name Phone Relationship

How Did You Hear About Us:_____

2 PERSON RESPONSIBLE FOR PATIENT/ACCOUNT

Name:_____Birthday:_____

Mailing Address:_____Apt#_____

City_____ State_____Zip_____

SSN:_____Relation To Patient:_____

PREFERRED CONTACT

☐ Home:_____
☐ Work: _____
☐ Cell: _____
☐ EMail: _____

3 *PRIMARY* DENTAL INSURANCE INFORMATION

Name of Policy Subscriber:_____Birthday:_____

Address:_____Apt#_____

City_____State_____Zip_____

Relation to Patient:_____

Insurance Company:_____Phone_____

SSN or Policy ID #_____Employer:_____Tel:_____

PREFERRED PHONE

☐ Home: _____
☐ Cell: _____
☐ Other: _____

4 *SECONDARY* DENTAL INSURANCE INFORMATION

Name of Policy Subscriber:_____Birthday:_____

Address:_____Apt#_____

City_____State_____Zip_____

Relation to Patient:_____

Insurance Company:_____Phone_____

SSN or Policy ID #_____Employer:_____Tel:_____

PREFERRED PHONE

☐ Home: _____
☐ Cell: _____
☐ Other: _____

OVER

DENTAL HISTORY

Reason for today's visit_____

Previous Dentist_____Address_____

Date of last: Dental visit_____Dental x-rays_____Cleaning_____

Check if you have had any of the following:

__Loose teeth or broken filling __Grinding teeth __Sensitivity to sweets
__Clicking or popping jaw __Bad breath __Sensitivity when biting
__Food collection between teeth __Periodontal treatment __Sensitivity to cold
__Sores or growth in your mouth __Bleeding gums __Sensitivity to heat

Do you require Pre-Medication? ____Yes ____No ____Do not know What is your Pre-Medication:_____

MEDICAL HISTORY

Today's Blood Pressure:_____

Physician's Name_____Date of last visit_____

WOMEN - Please check the following that apply to you:

Are you pregnant? __Yes __No Nursing? __Yes __No Taking birth control pills? __Yes__No

Check if you have had any of the following:

__AIDS
__Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Blood Transfusion
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Cough, Persistent
__Cough up blood
__Diabetes
__Epilepsy
__Fainting
__Glaucoma
__Headaches
__Heart Murmur
__Heart Problems
__Hemophila
__Hepatitis
__High Blood Pressure
__HIV Positive
__Jaw Pain
__Kidney Disease
__Liver Disease
__Mitral Valve Disease
__Nervous Problems
__Pacemaker
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__Shortness of Breath
__Skin Rash
__Stroke
__Swelling of Feet
__Thyroid Problem
__Tobacco Habit
__Tonsilitis
__Tuberculosis
__Ulcer
__Venereal Disease

Other medical conditions you have had or currently have:_____

List medications you are currently taking:_____

_____

_____

Are you allergic to any of the following? ____Latex ____Penicillin/Amoxicillin ____Dental Anesthetic

Other known allergies_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. Payment is due in full at time of treatment unless prior arrangements are approved. Late payments will be assested 1.5% monthly interest.

I AGREE THAT IF AN ACCOUNT REQUIRES OUTSIDE COLLECTION SERVICE, COLLECTION FEES WILL BE ADDED.

_____

Signature of Patient or Parent if minor Date

_____

Dentist Date