PATIENT INFORMATION

Welcome to Smile Craft Family Dentistry. Thank you for choosing our office to assist you with your dental needs. Please fill out the information below, and don't hesitate to ask any questions.

Patient Name: _____
Last First Middle Initial (Preferred)

Birthdate: _____ Gender: M F Other Married: Y N SSN: _____

If minor, name of legal guardian: _____ Relationship to Patient: _____

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

Email Address: _____ Emergency Contact Name: _____

Home Address: _____ Emergency Contact Phone: _____

City: _____ State: _____ Zip Code: _____

Dental Insurance Company: _____ (If applicable) ID Number: _____

How did you hear about us?

- ❑ Person (who): _____
- ❑ Referral (from): _____
- ❑ Website/Google
- ❑ Radio
- ❑ Other (please describe): _____

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist: _____

Do you have, or have you had any of the following?
(Please check any that apply)

❑ Bad breath	❑ Grinding teeth	❑ Sensitivity to hot
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between teeth	❑ Sensitivity to cold	❑ Sores or growths in your mouth

How often do you brush?

_____

How often do you floss?

_____

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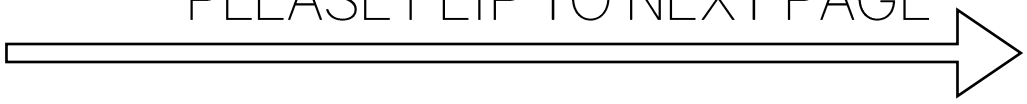

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates: _____

Do you smoke, vape, or use tobacco? ❑ Yes ❑ No

Women:
Are you pregnant? ❑ Yes ❑ No If yes, how many weeks? _____
Are you nursing? ❑ Yes ❑ No
Taking birth control pills or other form of contraceptive? ❑ Yes ❑ No

Do you have, or have you had any of the following?
(Please check any that apply)

❑ Are you required to pre-medicate before any dental treatment?

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cough, Persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valves	❑ Cough up Blood	❑ HIV/AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of Feet/Ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsillitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

❑ Other: _____

❑ None of the above

MEDICATIONS

List any medications you are currently taking:

_____

_____

Pharmacy Name: _____ Phone Number: _____

ALLERGIES

❑ Aspirin	❑ Amoxicillin/Penicillin
❑ Barbiturates (sleeping pills)	❑ Sulfa
❑ Codeine	❑ Latex
❑ Local Anesthetic	❑ Other: _____

❑ NO KNOWN ALLERGIES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PLEASE FLIP TO NEXT PAGE

Patient Registration Forms

You may be asked to sign these forms electronically as well. Thank you.

FINANCIAL AGREEMENT:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them. If insurance does not pay for treatment done, you are required to pay the balance off.

* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

* If sent to collections, I agree to pay all related fees and court costs.

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

* I will pay a fee for appointments broken without 24 hours notice.

* Treatment plans may change, and I will be responsible for the work done.

PATIENT INITIALS: _____

HIPAA PRIVACY:

I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission. A copy of the Notice of Privacy Practices are by request.

PATIENT INITIALS: _____

MEDICAL HISTORY:

Confirms what you marked on the medical history on the 'Patient Information' form is accurate and correct to the best of your knowledge. Confirms/denies any medications being taken, any allergies, and/or any medical issues/conditions.

PATIENT INITIALS: _____