Patient Information

Name: _____ Birth Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____Cell:_____

E-mail: _____ Social Security Number: _____

Sex: M F

Employer Name & Phone # (required):_____

Parent or Guardian (If patient is under 18 years of age)

Name: _____ Relationship to patient: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____Cell:_____

E-mail: _____ Social Security Number: _____

Employer Name & Phone # (required):_____

Insurance Information (No insurance? Just write SELF under "Name of Insured")

Name of Insured: _____

Relationship to Patient: _____

Date of Birth: _____ Social Security #:_____

Employer (Name & Address): _____

Insurance Company: _____

Group#: _____

Policy, Union or Local#: _____

Insurance Phone #:_____

Do you have Secondary Insurance? Y N

Share With Us

On a scale of 1 to10, how happy are you with your smile? 1 2 3 4 5 6 7 8 9 10

How did you hear about us? _____ If referred by a friend, who _____

Dental History

Date of last dentist visit: _____ Name of Previous Dentist _____

Reason for today's visit _____

Do you have any questions or concerns for the doctor? _____

_____

_____

Do you have a problem with the following? (Circle all that apply)

Bad Breath	Bleeding Gums	Sensitivity To Hot/Cold	Grinding Teeth
Loose Teeth	Sensitivity To Sweets	Sores In Your Mouth	Ugly Smile
Jaw Popping	Poor Fitting Dentures	Dry Mouth	Stained Teeth

Medical History

Date of last physicians visit: _____

Name of Physician_____

Physicians phone number: _____

(Women) Are you pregnant?_____

Have you ever had surgery? If so, when and why? _____

Do you have or have had any of the following? (Circle all that apply)

Anemia Arthritis Rheumatism Artificial Heart Valve Artificial Joints

Asthma Back Problem Bleeding Abnormally Blood Disease Cancer

Chemical Dependency Chemotherapy Circulatory Problem CHD

Cortisone Treatments Persistent Cough Bloody Cough Diabetes

Epilepsy Fainting Liver Disease Glaucoma Headaches

Heart Murmur Heart Problems Hemophilia Hepatitis

Hernia Repair High Blood Pressure HIV/AIDS Jaw Pain

Kidney Disease Liver Disease Mitral Valve Issues Pacemaker

Radiation Treatment Respiratory Disease Rheumatic Fever Scarlet Fever

Shortness of Breath Skin Rash Stroke Swelling of Feet Thyroid

Tobacco Habit Heart Attack Leukemia

Psychiatric Care Venereal Disease

List All Medications That You Currently Take: _____

_____

List All Allergies You Have Or May Have: _____

Authorization

I have completed the information on in-office or online registration forms to the best of my knowledge. I understand that it is my responsibility to inform the doctor if there have been any changes in my health and or my child's health. All care will be explained prior to treatment and will only be performed after I consent to such treatment. I authorize the doctor and any other employed staff (under doctor supervision and within the confines of the law) to perform any necessary treatments in regards to providing proper dental care.

Patient (or patient's parent or guardian): _____

Date: _____

Account:

You are fully responsible for payment of all dental services. If you have dental insurance, we will do our best to explain to you what is covered by your insurance and what you are responsible for. You are responsible for any deductible amounts or portions that your insurance does not cover. Our treatment plans are simply an estimate of what your insurance may cover. You are responsible for any portions of services not honored by your insurance company. You may be contacted in the future by our staff in regards to future appointments and for promotional purposes. Your information may be turned over to a third party collection agency in relation to collecting payment. By signing below you acknowledge that you have thoroughly read this document and that you understand it completely and accept its terms.

Patient (or patient's parent or guardian): _____

Date: _____

Appointments

We request 48 hours' notice to reschedule or cancel any appointment. This will allow us time to offer the newly available appointment slot to other patients. While we understand that unforeseen circumstances occur, we just ask that you please respect the time that we have reserved just for you. An assessed fee of $50 will be charged to your account for late notice and/or no shows.

An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for treatment. Our office policy is firm in this regard and we will not tolerate frequent cancellations or constant short-notice changes. We must have mutual respect for each other's time. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If three broken/missed appointments or three cancellations occur without 48-hour notice, our office reserves the right to NOT schedule any subsequent appointments. Also, if you arrive 15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.

Patient (or patient's parent or guardian): _____

Date: _____

I hereby give Elite Dentistry, and any and all employees, the right and permission to use and/or publish photographs of me and/or testimonials for art and promotional purposes (including but not limited to, advertising, publicity, commercial or display of use). I hereby release and discharge Elite Dentistry and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Patient (or patient's parent or guardian): _____

Date: _____