

SMILE SOLUTIONS

PATIENT INFORMATION (*CONFIDENTIAL*)

TODAY'S DATE _____

NAME _____ DR. MR. MRS. MISS MS.

ADDRESS _____ APT.# _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

BIRTH DATE _____ DL# _____

E-MAIL ADDRESS _____

RELATIVE/FRIEND LIVING IN SAN ANTONIO TO CONTACT IN CASE OF EMERGENCY:

_____ PHONE _____

_____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IF PATIENT IS A MINOR

PARENT OR GUARDIANS NAME _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL (COLLEGE) _____ CITY _____ STATE _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ DENTAL INSURANCE Co. _____

BIRTH DATE _____ SOCIAL SECURITY # _____

NAME OF EMPLOYER _____ INS. COMPANY PHONE # _____

GROUP # _____ SUBSCRIBER ID _____

OVER PLEASE

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ORGAN TRANSPLANT	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	CARDIAC PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	CHEST PAINS	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	EASILY WINDED	<input type="checkbox"/>	<input type="checkbox"/>
SWOLLEN ANKLES	<input type="checkbox"/>	<input type="checkbox"/>	ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>
FAINTING/SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	HAY FEVER/ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY/CONVULSIONS	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
LEUKEMIA	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>	RECENT WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS/JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>
AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH TROUBLES/ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF DRUG ABUSE	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN: ARE YOU PREGNANT? _____ ARE YOU TAKING ORAL CONTRACEPTIVES? _____

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW?..... | <input type="checkbox"/> | <input type="checkbox"/> | 3. DO YOU SMOKE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOU TAKING ANY MEDICATION INCLUDING NON-PRESCRIPTION MEDICINE?..... | <input type="checkbox"/> | <input type="checkbox"/> | 4. DO YOU USE SMOKELESS TOBACCO? | <input type="checkbox"/> | <input type="checkbox"/> |
| IF YES, WHAT MEDICATION(S) ARE YOU TAKING? | | | 5. ARE YOU ALLERGIC TO, OR HAVE YOU HAD ANY ADVERSE REACTION TO ANY MEDICATIONS?..... | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS _____

PATIENT DENTAL HISTORY

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. DO YOUR GUMS EVER BLEED WHILE BRUSHING OR FLOSSING?..... | <input type="checkbox"/> | <input type="checkbox"/> | 8. HAVE YOU HAD ANY ORTHODONTIC TREATMENT?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE?..... | <input type="checkbox"/> | <input type="checkbox"/> | 9. HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING A DENTAL PROCEDURE?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. WOULD YOU LIKE YOUR TEETH TO BE WHITER?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?... | <input type="checkbox"/> | <input type="checkbox"/> | 11. IS THERE ANYTHING ABOUT YOUR SMILE THAT YOU WISH YOU COULD CHANGE?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 6. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?
<input type="checkbox"/> CLICKING, <input type="checkbox"/> PAIN <input type="checkbox"/> DIFFICULTY IN OPENING & CLOSING | | | | | |
| 7. DO YOU CLENCH OR GRIND YOUR TEETH?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

COMMENTS _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE AFOREMENTIONED QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____
SIGNATURE OF PATIENT OR PARENT IF MINOR

Smile Solutions Financial Agreement

Financial Agreement For Our Patients Without Dental Insurance

PAYMENT IS EXPECTED AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Financial Agreement For Our Patients With Dental Insurance

OUR OFFICE WILL FILE YOUR INSURANCE CLAIM FOR YOU. THIS IS A SPECIAL SERVICE WE PROVIDE FOR OUR PATIENTS TO HELP ELIMINATE SOME OF THE OFTEN-CONFUSING PAPERWORK ASSOCIATED WITH PROCESSING CLAIM FORMS.

**For Our Patients With Insurance,
Please Select One Of The Following Options:**

Option 1

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. OUR OFFICE IS NOT A PARTY TO THAT CONTRACT. IF YOU PREFER WE WAIT FOR PAYMENT FROM YOUR INSURANCE COMPANY, WE REQUIRE A CREDIT CARD WITH AUTHORIZATION TO TRANSFER ANY BALANCE LEFT UNPAID BY YOUR INSURANCE COMPANY 30 DAYS AFTER THE DATE OF SERVICE.

CARDHOLDERS NAME _____

___ VISA ___ MASTER CARD ___ DISCOVER ___ AMERICAN EXPRESS

ACCOUNT # _____

SIGNATURE _____

EXP. DATE _____

Option 2

YOU CHOOSE TO PAY YOUR BALANCE IN FULL ON THE DATE OF SERVICE. WE WILL SUBMIT YOUR INSURANCE CLAIM FOR YOU WITH DIRECTIONS TO SEND THE REIMBURSEMENT DIRECTLY TO YOU.

I have read Smile Solutions Financial Agreement and have selected my form of payment.

PATIENT OR GUARDIAN SIGNATURE