Patient Information

Patient Name: _____ Date:_____
Last First M.I.

Patient Address: _____ * _____ * _____ * _____ * _____
Street Apt. # City State Zip

Patient Home Phone: _____ * Work Phone: _____ * Cell/Other Phone: _____

Patient Social Security #: _____ - ____ - _____ Patient Birth Date: _____ / _____ / _____

Driver's License #: _____ * E-Mail: _____

Patient Employer Name: _____ * Occupation: _____

Employer Address: _____ * _____ * _____ * _____
Street City State Zip

☺ *Whom May We Thank For Referring You?* _____

Person Responsible For Payment

NOTE: You may skip the following information if it is the same as above

Name: _____ * Birth Date: ___ / ___ / ___ * SS#: _____ - ___ - _____
Last First M.I.

Address: _____ * _____ * _____ * _____ * _____
Street Apt. # City State Zip

Home Phone: _____ * Work Phone: _____ * Cell/Other Phone: _____

Driver's License #: _____ Relation to Patient: _____

Employer Name: _____ * Occupation: _____ * E-Mail: _____

Employer Address: _____ * _____ * _____ * _____
Street City State Zip

Insurance Information

PRIMARY POLICY HOLDER:

Name: _____ * Birth Date: ___ / ___ / ___ * SS#: _____ - ___ - _____
Last First M.I.

Employer Name: _____ * Employer Address: _____

Insurance Company Name: _____ * Phone #: _____ * Group # _____

Insurance Company Address: _____

SECONDARY POLICY HOLDER:

Name: _____ * Birth Date: ___ / ___ / ___ * SS#: _____ - ___ - _____
Last First M.I.

Employer Name: _____ * Employer Address: _____

Insurance Company Name: _____ * Phone #: _____ * Group # _____

Insurance Company Address: _____

Consent for Services

The undersigned hereby authorizes Elite Dental to order x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by us to make a thorough diagnosis of the patients dental needs. I authorize The Smile Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I authorize and consent that Elite Dental choose and employ such assistance as deemed fit to provide recommended treatment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Following diagnosis we will advise you of our treatment plan for you. After mutual agreement on your treatment plan, treatment will be rendered.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Should the insurance company decide not to contribute or pay less than the "**guesstimate**", you, the patient will be responsible for any difference owed. You will be presented various financial options and given an opportunity to select the plan that best suits your needs.

A service charge of 1½% per month (18% per year) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Elite Dental, I agree to pay therefore the reasonable value of said services to Elite Dental, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health and information on this form, I will inform the doctor at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Rescheduling Notice

To be able to serve all patients with the same commitment, keep in mind that schedule appointments are extremely precious. If you cannot keep a scheduled appointment, 2-business day's cancellation notice by you is required. We do realize that certain emergencies are unavoidable and will take this into consideration.

Missed appointments without a 2-business day's notice will be charged at the rate of $50 for each hour scheduled. Please remember that other patients may have needed your scheduled time.

Patient Initials:_____

Don’t Wait Until it Hurts. Let Us Help.

Dental Information

1 Are your teeth sensitive to heat or cold? Yes____ No____ Pressure? Yes____ No ____ Sweets? Yes____ No____

2 Do you grind or clench your teeth? _____

3 Do you have any fear of dental work? _____

4 Date of last dental work? _____

5 Former Dentist name and address _____

6 What was done at that time? _____

7 How would you describe your current dental problem? _____

_____

8 How do you feel about the appearance of your teeth? _____

9 What changes would you like to see in the appearance of your smile? _____

_____

_____

10 Do you suffer from chronic, tension or migraine headaches? Yes ____ (please circle) No ____

American Dental Association Warning Signs of Periodontal Disease

Periodontal disease is painless. It affects 75% of the population, and often victims are unaware

11 Gums that bleed when you brush your teeth? Yes ____ No ____

12 Gums are red, swollen or tender? Yes ____ No ____

13 Gums have pulled away (receded) from teeth? Yes ____ No ____

14 Pus between teeth and gums when gums are pressed? Yes ____ No ____

15 Permanent teeth are loose or separating? Yes ____ No ____

16 Change in the way your teeth fit when biting? Yes ____ No ____

17 Any change in fit of partial dentures? Yes ____ No ____

18 Persistent bad breath? Yes ____ No ____