NU SMILE

It Looks Good On You!

PATIENT INFORMATION

Patient Name:_____

Last First MI (Preferred Name)

Date of Birth: _____ Family Status: Married Single Child Gender: M F

Phone # Home: _____ Mobile: _____ Work: _____

Email: _____ Do you prefer email OR text communications?

Address: _____

Street Apartment #

_____

City State Zip Code

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies:_____
- _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy (currently)
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

Complete Information Below and Circle Those Answers That Apply:

Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

Are you now under the care of a physician? Yes No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

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, I will inform the doctors at the next appointment without fail._____ Date: _____

Signature of patient, parent or guardian

Yes, you may use my testimonial, photos and name to let other patients about my great experience with your office.

Patients signature:_____ Date: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

The following is for: the patient's spouse the person responsible for payment

Name: _____

Birth Date: _____ Male Female Married Single Child Other

Phones: Home: _____ Mobile:_____ Work: _____

Address: _____

City: _____ State: _____ Zip Code: _____

EMPLOYMENT INFORMATION

The following is for: Patient Response Party

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Social Security #: _____

Insured's Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name:

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

FINANCIAL POLICY AND CONSENT FOR SERVICES

1. Our policy is that payment for services be made at the time of service, in the form of cash, check, or Credit Card.

2. Because our time, and yours, is valuable in maintaining the operations of this endeavor,and your appointment affects many others, we ask as a courtesy to us and to our other patients that you notify us if you cannot meet a scheduled appointment with a 48 hour notice.

3. The fee estimate listed for this dental care can only be extended for a period of six months from the date of the examination.

4. While the filing of insurance claims is a courtesy that we extend to our patients, we must emphasize that as dental care providers, our relationship is with the patient and not the insurance company. We will submit your claim and assist you to receive a reimbursement – but ultimately the payment is your responsiblility.

5. I, the undersigned, hereby authorize release of insurance payments, benefits, and records to the Doctor.

6. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor at the time said services are rendered. I further agree to pay all costs and reasonable attorney fees, if necessary to 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.

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

Signature of Patient, Parent or Guardian_____ Date: _____

Relationship to Patient: _____