

Please complete front and back

**Perfect Smiles Dental Care, P.A.**

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Name: (Mr. Mrs. Ms. Dr.) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

How do you prefer to be contacted by our office?  Cell  Home  Work  Email

Best Time To Contact You: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Responsible Party for this Account: \_\_\_\_\_ Relation: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Insured's Full Name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employers Address: \_\_\_\_\_

H.R. Phone \_\_\_\_\_ (in case we need information on the insured)

**If under 18**, Parent's Name-Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Work#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_ (If Primary Insured)

Person to notify in an Emergency: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Work#: \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

Home Flyer  Post Card/Brochure  Website  Radio Ad  KC Star Insert

Britesmile Website  Invisalign Website  Newspaper Ad/Insert

**Medical History**

Your personal physician's name: \_\_\_\_\_

Are you presently under a physician's care? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Have there been any significant changes in your health within the past year?

Have you ever been told by a physician to use antibiotics before any medical or dental treatment?

Yes  No {heart murmur, artificial joint or mitral valve prolapse}

Your current physical health is:  Excellent  Good  Fair  Poor

Please complete front and back

Have you been diagnosed with a serious illness, hospitalized or undergone an operation within the past five years? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

**Please place a check mark if you are allergic to any of the following:**

- Penicillin    Codeine    Aspirin    Dental Anesthetics    Erythromycin  
Latex Gloves    Sulfa Drugs    Other: \_\_\_\_\_

**Please check if you have any now or have had any of the following:**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Problems, Heart Attack or Murmur          | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> High Blood Pressure                             | <input type="checkbox"/> Low Blood Sugar            |
| <input type="checkbox"/> Low Blood Pressure                              | <input type="checkbox"/> Fainting Spells//Dizziness |
| <input type="checkbox"/> Rheumatic Fever or Heart Disease                | <input type="checkbox"/> Nervous Disorder           |
| <input type="checkbox"/> Prescription Drug or Cocaine Dependency         | <input type="checkbox"/> Sinus Problems             |
| <input type="checkbox"/> Bleeding/Clotting Disorder or Blood Transfusion | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Mitral Valve Prolapse                           | <input type="checkbox"/> Psychiatric Care           |
| <input type="checkbox"/> Leaky Heart Valve                               | <input type="checkbox"/> Chemotherapy               |
| <input type="checkbox"/> Headaches/Migraines                             | <input type="checkbox"/> Glaucoma                   |
| <input type="checkbox"/> Artificial Joint Replacement                    | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> Hepatitis                                       | <input type="checkbox"/> Tumor/Growth               |
| <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Respiratory Problems       |
| <input type="checkbox"/> Liver Disease                                   | <input type="checkbox"/> Asthma                     |
| <input type="checkbox"/> Stroke  | <input type="checkbox"/> Emphysema                  |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Epilepsy                   |
| <input type="checkbox"/> HIV or AIDS                                     | <input type="checkbox"/> Kidney Problems            |
| <input type="checkbox"/> Other: _____                                    |   |

What medications are you now taking? \_\_\_\_\_

**Women Only:** Pregnant    Nursing    Taking Birth Control Pills

**Responsible Party Contract**

I affirm the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical history and dental insurance status. I will not hold the doctor responsible for any omissions I have made in the completion of this form. I authorize and give consent to the doctor to perform dental services agreed between the doctor and me and/or parent or guardian to be necessary or advisable including the use of local anesthetics and other medications as indicated. ***I understand payment for all treatment and services rendered are my responsibility. Any expected payment from my insurance company is an estimate only and I am responsible for all fees in their entirety. I also understand my dental benefits are based upon a contract between my employer and insurance company and not this dental office. I am responsible for the total fee if the insurance company does not pay for a particular service and/or responsible for the difference if the insurance only partially pays for the service.*** I also understand if prior assigned financial arrangements have not been made, then the fee is due, in full, the day of the service. No balances shall be carried by this dental office for more than 60 days after the dental service. If balances are carried for more than 60 days, I understand that a finance charge will be applied. For this office to accept my insurance or to offer payment plans, I will be subject to a credit evaluation. If my account is sent to a collection agency or an attorney for non-payment, I will be responsible for the collection fees, attorney fees and accruing interest in addition to my unpaid balance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_