SMILE PERFECTORS

CRYSTAL CITY DENTAL ARTS CENTER

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ Email Address _____ Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City _____ State_____ Zip _____

Sex: ❑ M ❑ F Age_____ Birthday_____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse Birth date _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone_____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouses Social Security # _____

Primary Insurance Company Name _____ Group Number_____

Second Insurance Company Name (If Applicable)_____ Group Number_____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical _____

Have you ever had any of the following? (check the boxes that apply)

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Problems	❑	❑	Epilepsy	❑	❑	Special Diet
❑	❑	Heart Murmur	❑	❑	Headaches	❑	❑	Swollen Neck Glands
❑	❑	High/Low Blood Pressure	❑	❑	Hepatitis, Jaundice or Liver Disease	❑	❑	Rheumatic Fever
❑	❑	Artificial Heart Valves or Joints	❑	❑	Cancer	❑	❑	Sinus Problems
❑	❑	Circulatory Problems	❑	❑	Psychiatric Care	❑	❑	"A.I.D.S." or Other Immunosuppressive Disorders
❑	❑	Nervous Problems	❑	❑	Chronic Diarrhea			
❑	❑	Radiation Treatment	❑	❑	Allergies to Anesthetics	❑	❑	Stroke
❑	❑	Recent Weight Loss	❑	❑	Allergies to Medicine or Drugs	❑	❑	Ulcer
❑	❑	Back Problems	❑	❑	General Allergies	❑	❑	Venereal Disease
❑	❑	Diabetes	❑	❑	Blood Disease	❑	❑	Chemical Dependency
❑	❑	Respiratory Disease	❑	❑	Arthritis	❑	❑	Hemophilia

Date of last dental check-up_____ Dentist's Name _____

Reason for today's visit:_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____

_____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Are you under the care of a physician? ❑ Yes ❑ No For what conditions? _____

(Women) Do you suspect that you are pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

PLEASE READ AND SIGN:

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

There will be a $60.00 per 1/2 hour charge for appointments cancelled or broken without 48 hours advance notice **(No exceptions)**.

It is agreed that all expenses incurred by our office in enforcing its rights to payment for services rendered, including attorney's fees in the amount of $35% and all other court costs so incurred shall be recoverable from the client (patient).

Signature X _____ Date_____