Perfect Smile Dental :)
8965 S. Eastern Ave.
Suite 100
Las Vegas, NV 89123
702-387-6453

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call:_____

E-Mail Address: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____ Relationship: _____
Name Phone

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

Health Information

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

Why did you leave your last dentist? _____

- I consider my dental health to be (Circle One): Excellent Good Poor
- Present dental problems: _____
- If I could change my smile, I would…_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____

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

- ☐ Allergies: _____ _____
- ☐ Anemia/Excessive Bleeding
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cardiovascular Disease (Heart Attack, Coronary Artery Disease, Angina, Palpitations, Heart Surgery?)
- ☐ Cold Sores
- ☐ Congenital Heart Disease
- ☐ Diabetes (I, II)
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, C, D)
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee?)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease (Asthma, Emphysema, Chronic or Severe Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain?)
- ☐ Mental/Nervous Disorders
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ OTHER: _____

- 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:_____
  Date of last exam: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Height_____ Weight _____

Are you taking any of the following? Please check those that apply:

- ☐ Antibiotics?
- ☐ Anticoagulants (Blood Thinners)?
- ☐ Aspirin or drugs such as Motrin, Aleve, Ibuprofen?
- ☐ High Blood Pressure Medications?
- ☐ Steroids (Cortisone, etc.)?
- ☐ Tranquilizers?
- ☐ Insulin or Oral Anti-Diabetic drugs?
- ☐ Digitalis, Inderal, Nitroglycerin, or other heart drug?
- ☐ Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)?
- ☐ Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
  _____
  _____

- Do you smoke or chew tobacco? ☐ Yes ☐ No How much per day? _____
- Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ☐ Yes ☐ No
- Have you or an immediate family member had any problem associated with intravenous anesthesia? ☐ Yes ☐ No
- Do you wish to talk to the doctor privately about anything? ☐ Yes ☐ No

FOR WOMEN ONLY

- Are you pregnant, or **<u>is there any chance</u>** you might be pregnant? ☐ Yes ☐ No
- Are you nursing? ☐ Yes ☐ No

- If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

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

Spouse or Responsible Party Information

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

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

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

Last First MI

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

Insured's Social Security #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

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

Last First MI

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

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash 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. As a courtesy, our office will submit your dental claim; however you are ultimately responsible for any charges your insurance does not reimburse.

A service charge of 1½% per month (18% per annum) 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 ninety (90) days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. 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.

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

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party