THE HARTLAND SMILEMAKERS™

The Hartland Smilemakers™

KENNETH F. McDANIEL, D.D.S., P.C.

This personal information will help us give the most consideration of your time and feelings and enable us to better work with you to meet the needs of you and the patient. It is important to have complete answers. All information is, of course, confidential.

PLEASE PRINT

Patient's Name_______________ Nickname_______________ Birthdate _______

Address_______________ City_______________ State________ Zip _____

Home Phone No._______________ E-Mail_______________ Cell _______________

Patient's Social Security Number_______________ School_______________ Grade_______________

PARENT'S INFORMATION

* **Father's Name**_______________ Birthdate _______________

Address_______________ City_______________ State________ Zip _____

Home Phone No._______________ Employer_______________ Soc. Sec. No. _______________

Emp. Address_______________ City _______________ State _______________ Zip _______________ Phone No. _______________

Employee's Dental Insurance_______________ Group No._______________

* **Mother's Name**_______________ Birthdate _______________

Address_______________ City_______________ State________ Zip _____

Home Phone No._______________ Employer_______________ Soc. Sec. No. _______________

Emp. Address_______________ City _______________ State _______________ Zip _______________ Phone No. _______________

Employee's Dental Insurance_______________ Group No._______________

PATIENT'S DENTAL HISTORY

Is this patient's first visit to a dental office?____________ If not, how long since the last visit _______________

What was done at that time?_______________ Is the patient having any discomfort or pain? ______

If yes, please explain _______________

PATIENT'S MEDICAL HISTORY

Has the patient ever had any serious illnesses, such as rheumatic fever, any kind of heart problem or heart murmur, diabetes, etc._________ If yes, please explain_______________

Is patient sensitive or allergic to any food or medication?__________ If so, what _______________

Date of patient's last medical checkup_______________ Is patient under treatment at present? _______________

If so for what?_______________ What medication does the patient take? _______________

* MAY WE ASK WHO RECOMMENDED THIS OFFICE?_______________

PLEASE CONTINUE ON BACK

HEALTH INFORMATION

Please **CIRCLE** if you have had any of the following:

		Scarlet Fever	Cancer	Hypoglycemia
Heart Trouble	Chest Pain	Asthma	Thyroid Disease	Psychiatric Care
High Blood Pressure	Shortness of Breath	Hay Fever	Parathyroid Disease	Drug Addiction
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Heart Murmur	Fainting or Dizziness	Emphysema	Chemotherapy/Radiation	Hemophilia
Rheumatic Fever	Stroke	Frequent Cough	Arthritis/Gout	AIDS
Congenital Heart Lesion	Diabetes	Lung Disease	Rheumatism	Venereal Disease
Artificial Heart Valve	Excessive Thirst	Tuberculosis	Pain in Jaw Joints	Cold Sores
Heart Pacemaker	Artificial Joints/Hips	Liver Disease	Cortisone Medicine	Fever Blisters
Heart Surgery	Kidney Trouble	Hepatitis A (infec.)	Glaucoma	Herpes
Blood Disease	Ulcers	Hepatitis B (serum)	Epilepsy or Seizures	Bruise Easily
Anemia	Allergies	Yellow Jaundice	Nervousness	Sickle Cell

None of the above_____________

Please describe in detail any serious illness not circled above.____

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FINANCIAL INFORMATION

Our office policy requires that your obligation (or ESTIMATED insurance copayment) be paid by the time treatment is completed. Please advise our receptionist if other arrangements are necessary, BEFORE SEEING THE DOCTOR. We will be happy to help you ESTIMATE your copayment based upon our previous experience of what a particular Insurance Company has paid in the past. WE CANNOT GUARANTEE THAT YOUR DENTAL PLAN WILL PAY ANY OR ALL OF YOUR BALANCE. In all cases, balances remaining after insurance has paid will be billed to you. We accept cash, personal checks on local banks, money orders, VISA, Master Card, Discover, and American Express.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST BY MY INSURANCE CARRIER FOR SERVICES RENDERED

I AUTHORIZE EITHER OF THE DENTISTS TO RELEASE ANY INFORMATION NECESSARY TO PROCESS CLAIMS.

I AGREE TO BE RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY DENTAL PLAN.

Name of person financially responsible for this patient ______________________________________
(Please Print)

Date______________________________ Signature ______________________________________
I assume full responsibility for payment of all charges incurred by the above named patient.