HARTLAND SMILEMAKERS™

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Patient's Full Name _____ What do you prefer to be called? _____

Birth Date _____ Social Security No. _____

Cell No. _____ Home No. _____ E-mail _____

Home Address _____ City _____ Zip_____

Employer _____ Work Phone No. _____

PRIMARY Dental Insurance _____ Group No. _____

SECONDARY Dental Insurance _____ Group No. _____

Spouse's Name _____ Social Security No. _____ Birth Date _____

Employer & Phone No. _____

Emergency Contact _____Relationship:_____Phone #_____

How did you hear about us? Please check all that apply:
☐ Friend or Family/Name: _____, Insurance Company ☐ Website ☐, Google ☐ , Drive By/Sign ☐ Newspaper ☐
Other:_____

MEDICAL HISTORY

Medical doctor's name, address _____

Are you under a doctor's care now? Why? _____	YES	NO
Have you been hospitalized during the past two years? Why?_____	YES	NO
Are you taking any medications, pills, or drugs? What? _____	YES	NO
Are you allergic to any medications, metals or materials? What? _____	YES	NO
Are you pregnant? (women) _____	YES	NO

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

AIDS	Chest Pain	Heart Murmur	Liver Disease	Scarlet Fever
Anemia	Congenital Heart Lesion	Heart Surgery	Low Blood	Sinus Trouble
Artificial Heart Valve	Cold Sores	Hemophilia	Lung Disease	Stroke
Artificial Joints/Hip	Diabetes	Hepatitis A or B	Nervousness	Swelling of Feet/Ankles/Hands
Asthma	Drug Addiction	Herpes	Pacemaker	Thyroid Disease
Blood Disease	Emphysema	High blood pressure	Pain in Jaw	
Cancer	Epilepsy or Seizures	Hypoglycemia	Psychiatric Care	
Chemotherapy/Radiation	Glaucoma	Kidney Trouble	Rheumatic Fever	None of these

Is there a family history of diabetes? If yes, relationship_____
Have you ever had other serious illness not circled above? _____

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, balance's remaining after insurance has paid, will be billed to you.** We accept cash, local personal checks, money orders, VISA, Master Card, American Express, Discover and Care Credit.
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST BY MY INSURANCE CARRIER FOR SERVICES RENDERED.
I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION NECESSARY TO PROCESS CLAIMS. I AGREE TO BE RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY DENTAL PLAN.

Signature _____ Date _____

-PLEASE CONTINUE ON PAGE 2-

PRE-CLINICAL INTERVIEW

What can I do for you today? _____

Are you having any pain or discomfort? Please explain_____

When was your last dental visit? _____ What was done? _____

What was your reason for leaving your former dentist? _____

Are you nervous about seeing the dentist? _____

During treatment are you interested in using nitrous oxide? _____ Or head phones? _____

Have you lost any permanent teeth? _____ Why? _____ How long ago? _____

Are you interested in replacements? _____

Do your gums ever bleed, feel irritated, tender or swollen? _____ When? _____

Does food get caught between your teeth when you chew? _____ Where? _____

Do you smoke? _____ How much? _____

Do you have pain in you teeth because of heat? _____ Cold? _____ Sweets? _____ Or pressure? _____ Where? _____

In your opinion, what is the overall condition of your teeth? _____ Gums? _____

Are you please with the appearance of your teeth? _____ Would you like whiter teeth? _____

Do you or any member of your family have a problem with snoring? _____

What do you expect from your dentist? _____

SOCIAL MEDIA RELEASE FORM

I give permission to the Hartland Smilemakers for the use and disclosure of my name and photos/videos of me related to my experiences here in the HSM office. I acknowledge that my name and photos/videos will be used on social networking sites all in a positive nature through advertising to promote the HSM business. I acknowledge and agree that no payments will be made to me for use of my photos/videos and/or name. I have read this release form and agree to the above terms.

Patient Signature:_____ Parent or Legal Guardian Signature: _____

Date: _____

I ***do not*** give the Hartland Smilemakers permission to take any photos of me or my child for social networking sites.

Patient Signature:_____ Parent or Legal Guardian Signature: _____

Date: _____