THE HARTLAND SMILEMAKERS
810-632-5533

HARTLAND SMILEMAKERS

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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 Name _____ Nickname _____ Birth date _____
Address _____ City _____ State _____ Zip _____
Home Phone No. _____ E-Mail _____ Cell _____
Patient's Social Security No. _____ School _____ Grade _____

*****PARENT'S INFORMATION*****

Father's Name _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Home Phone No. _____ Employer _____ Social Security No. _____
Emp. Address _____ Phone No. _____
Employee's Dental Insurance _____ Group No. _____

Mother's Name _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Home Phone No. _____ Employer _____ Social Security No. _____
Emp. Address _____ Phone No. _____
Employee's Dental Insurance _____ Group No. _____

*****PATIENT'S DENTAL HISTORY*****

Is this the 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 what for? _____ What medication does the patient take? _____

WHOM MAY WE THANK FOR RECOMMENDING YOU TO OUR OFFICE? _____

-PLEASE CONTINUE TO PAGE 2-

HEALTH INFORMATION

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

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

None of the above_____

Please describe in detail any 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, 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.