elite SMILES
DENTISTRY

Guest Registration

First Name: _____ Last Name: _____ Middle Initial: _____

What would you like us to call you: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Soc. Sec.: _____

Emergency Contact: _____ Phone number: _____

How did you hear about us (e.g. friend, website, TV, radio)? _____

Preferred Pharmacy: _____

Responsible Party (if different than the guest)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Soc. Sec.: _____

Insurance information

Name of Policy Holder: _____

Patient's Relation to Policy Holder: O Self O Spouse O Child O Other

Policy Holder's Birth Date: _____ Policy Holder's Soc. Sec.: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Insurance group number/policy number: _____

Sleep and Smile Information

Do you snore? Y / N Do you have sleep apnea? Y / N Do you get a good night's sleep Y / N

Would you like whiter teeth? Y / N Would you like straighter teeth? Y / N

TIME 11:49 AM

Elite Smiles

DATE 2/26/2016

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

elite SMILES
DENTISTRY

Welcome to Elite Smiles! You have chosen one of the most advanced dental offices in the entire country in both technology and training. We are committed to your oral health and will devise a strategy to maintain your health for years to come. In order for us to attain these results we will need your help We need to make sure the guidelines of the practice are followed so that your oral health is not compromised.

1. We reserve time for just one guest at at time. We do this because we value your time and in turn we must only treat guests that value ours. When reserving time at our office please make sure this works for your schedule. Canceled appointments make it impossible to provide you with the level of care and personal attention that we strive for. Canceled **appointments with less than 24 hours notice will incur a $35.00 charge and if "3" reservations are missed we reserve the right to help you find another dentist.**
2. We welcome most dental benefits plans in our office and help you to maximize those benefits. However, it must be realized that dental insurance is designed to help primarily with preventive care, not extensive treatment. Therefore it is difficult to tell what your insurance company will cover. It is for this reason that **we will provide you with an estimate of what your company will provide, not a guarantee.** Your insurance company may tell you that the charges incurred by you are more than your policy allows, or that it could have been accomplished using less expensive and lower quality alternative. This is your insurance company's way of limiting your benefits and increasing their profits.
3. We have a number of ways for you to pay for your investment in dental health. We accept cash, check and most major credit cards. If a check fails to clear a $50.00 administrative fee will be accessed. We also offer Care Credit which is line of credit that can be used specifically for medical needs at low monthly payments. **We make all these options available to you because each day's treatment must be paid in full before starting.** Should any account reach 90 days past due, you will be responsible for all administrative fees associated with the collections process.
4. It is important that you ask questions. Again, we are not like other offices. You are the only one we have reserved time for at that moment and we want everything to be clear. We offer a wide variety of treatment in our office from veneers and "smile makeovers", to TMJ/Migraine treatment, to one visit dental crowns and many other treatments. Let us know what is best for you or what we can do to make each visit as enjoyable as possible. We have a full beverage center for you, headphones, blankets and pillows. Please ask if there something you need.

These guidelines are in place to help insure that you receive undivided attention in the development and execution of your personalized dental plan. They allow us to use the latest technology, the best dental technicians and provide personalized attention. Thank you for choosing Elite Smiles, please sign and date below that you have read the guidelines, agree to them, and have no questions. In stating so, you agree to allow Dr. Freeman to take all necessary radiographs and perform all necessary treatments and procedures that he deems necessary. By signing below, you permit us to leave messages for you on your answering machine and/or voicemail You also acknowledge that you received/reviewed a copy of Dr. Steven Freeman's Notice of Privacy Practices **(UPDATED September 23, 2013)**, and is posted in the office.

Guest name: _____ Signature: _____

Name of person/persons that information can be released to: _____

DATE: _____