TIGER SMILE
Family Dentistry

Name:_____ **Age:**_____ **Birth Date:**_____ **Sex F M**

Address:_____ **Apt#:**_____ **City:**_____ **State**_____ **Zip:**_____

Phone (Home):(____)_____ **Work (____)**_____ **Ext:**_____

Cell Phone ( ) _____ **E-mail address** _____

Social Security No.:_____

Whom may we thank for this referral?_____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health.

Physician:_____ **Office Phone:**_____

Are you under any medical treatment now? ..... Yes No
Are you taking any medication? ..... Yes No

_____

Are you allergic to any medication, local anesthetic or material (such as nickel) resulting in hives, asthma, etc.? ..... Yes No

_____

Have you ever had any major operations?..... Yes No
Have you had any complications after teeth extractions such as prolonged bleeding? ..... Yes No
Do you use or have you ever used tobacco products? ..... Yes No

Would you like to know what options are available to you to help you have a more attractive smile? ..... Yes No

Do you have or have you ever had: Circle all that apply

Mitral Valve Prolapse	Liver Disease	Tuberculosis
Heart Condition	Blood Transfusions	Anemia
High/Low Blood Pressure	Hepatitis/Jaundice	Epilepsy
Do you have a Pacemaker	Nervous Disorder	Diabetes
Artificial Joint/Heart Valves	Respiratory Disease	Asthma
Cortisone-Steroid Treatment	Heart Murmur	Rheumatic Fever
Tumor or Malignancy	Scarlet Fever	Venereal Disease
Thyroid Problem	Kidney Disease	AIDS/HIV Positive
Arthritis	Blood Disease	Are you Pregnant? Yes No If yes, delivery date _____

Medications:_____
_____

Last dental visit_____ **Were x-rays taken at that time**_____ **Were your teeth cleaned at that time**_____
Do you have an immediate dental problem_____ **If so, where**_____

PATIENT OR LEGAL GUARDIAN SIGNATURE_____ DATE_____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN PATIENT)

NAME_____ BIRTHDATE_____

ADDRESS_____APT#_____CITY_____STATE____ZIP_____

SOCIAL SECURITY NO._____ PHONE_____

DENTAL INSURANCE INFORMATION

Subscriber Name:_____
Last First
Date Of Birth:_____ Subscriber ID#:_____

Group/Employer Name:_____ Group#_____

Insurance Company Name:_____

- **I authorize release of any information concerning my/my child's health care recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.**
- **I authorize Payment of insurance benefits directly to (Tiger Smile Dental)**
- **I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.**
- **I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.**
- **I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental serviced are rendered.**
- **I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental insurance benefits.**

Deposit for treatment: A prepaid deposit of 50% is required when scheduling treatment. 5% prepaid discount will be given if treatment is paid in full.

Patient/Guardian Signature:_____ Date:_____