



PATIENT

Title	First Name	M.I.	Last Name	Preferred Name
Mailing Address			City/State	Zip
Home Phone ()		Cell ()		Other/Work ()
Date of Birth		Male____ Female____	Employer	
Social Security #			Driver's License #	
Email			Family Physician	
Preference for Confirming Appointments: (circle one) Email Text Phone			Emergency Contact & Number	
How did you hear about us?			Dentist Preference	

PERSON RESPONSIBLE FOR FINANCIAL OBLIGATIONS (If different from above)

Name	Last Name	Relation to Patient
Mailing Address	City/State	Zip
Home Phone ()	Cell ()	Other/Work ()
Date of Birth	Social Security #	Driver's License #
Email	Do we have permission to contact you via Email, Text or Voicemail regarding your financial obligations? Yes No	

Primary Dental Insurance

Policy Holder's Name	Name of Insurance
ID Number/SSN	Policy/Group Number
Employer	Policy Holder's Date of Birth

Secondary Insurance

Policy Holder's Name	Name of Insurance
ID Number/SSN	Policy/Group Number
Employer	Policy Holder's Date of Birth

	Yes	No
1. Has it been over 1 year since your last dental appointment? If so, how long?		
2. Do you have anxiety in the dental chair?		
3. Are you happy with the color, shape, position of your teeth/ smile?		
4. Are you here for a specific reason today? If so, what?		

PATIENT MEDICAL HISTORY

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



If not, please check "None of the Above."

Acid Reflux	History of Alcohol/ Drug Abuse
ADD/ADHD	HIV, AIDS, Hepatitis, other Contagious Disease
Allergy to Latex	Immune Issue/ Disorder
Angina/ Chest Pain	Irregular Heart Beat
Arthritis /Joint Disease	Joint Replacement (Hip, Knee, etc.)/ Date?
Asthma	Low Blood Pressure
Autism	Mental or Physical Disability/ Specify:
Blood Disorder/ Anemia/ Transfusions	Nervousness/ Anxiety
Blood Thinner	Night Sweats
Cancer/ What type?	Organ Surgery/ Loss of Major Organ Transplant
Cardiac Pacemaker	Osteoporosis/ Osteopenia
Chronic Fatigue	Parkinson's Disease
Clench/Grind Teeth/ When did this begin?	Popping of Jaw/ Clicking of Jaw / When did this begin?
Congenital Heart Disease/Defect*	Pregnant Currently / Due date?
Depression	Prosthetic Heart Valve/ Shunt/ Stent/ Year placed?
Diabetes/ Low Blood Sugar	Radiation or Chemotherapy
Dialysis/ Kidney problem/Kidney Disease	Respiratory Disease
Emphysema/ COPD/ Difficulty Breathing	Rheumatic Fever or Rheumatic Heart Disease*
Epilepsy/Seizures	Sinus Issues/ Surgery
Excessive Bleeding or Bruising	Sleep Apnea/ Are you treated?
Fainting Spells / Dizziness	Snore
Glaucoma	Steroid Treatments/ Cortisone
Hay Fever	Stomach Ulcers/ Colitis
Head Injury	Stroke
Headaches/ How often?	Temporomandibular Joint Disorders/ (TMJ)
Heart Disease/ Heart Attack	Thyroid Issues
Heart Murmur or Prolapsed Valve	Tuberculosis
Heart Shunt/ Stent	Venereal Disease
Heart Surgery/ Specifically for what?	None of the Above
High Blood Pressure	
High Cholesterol	

YES NO

1. Are you taking any medications? List Medication/ Reason/ Frequency:		
2. Have you ever had any ALLERGIC / ADVERSE REACTIONS to anesthetics/ antibiotics/ medications? List:		
3. Are you under the care of a physician for a current problem? If yes, explain:		
4. Have you been hospitalized within the past 5 years? Please specify.		
5. Is there any other condition concerning your health about which the doctor should be told? Specify:		

Please Sign After Reading:

Charges for dental services are due at time of the service. Payment may be made with cash, check, Visa, MasterCard, AMEX or Debit cards and Care Credit After 60 days, all balances will accrue a 1.5% financial charge.

I understand that I (or the guarantor listed) am ultimately responsible for any delinquent charges on this account (including those in association with the Practice, collections agencies and/or attorney's fees.)

Patients with Insurance: As a courtesy to our patients, this office will file and process my dental insurance claims for my convenience. There is never a guarantee that insurance will assist with payments and I understand that financial obligations are ultimately that of the patient. I understand that I am fully responsible for all financial obligations for services rendered at this office excluding any assistance provided by my insurance payments and am aware that if my insurance has not paid the doctor(s) within six (6) weeks from the date of service, **I am responsible for paying the entire balance immediately.**

I understand that the contract I hold with my Insurance Carrier is independent of Tiger Smile Dental. I also understand that any fees expected/quoted to be paid by my insurance company are ***only estimates***. I authorize payment of the dental benefits from my insurance to be payable to the doctor(s) of Tiger Smile Dental.

Consent: It is necessary for us to have the consent of our patients or a parent/ legal guardian of minors. The signature below therefore authorizes the doctor to perform any and all forms of dental treatment, use dental products/ materials, and/or therapy that has been presented and agreed upon (includes written and/or verbal agreements). I understand that although rare, dental treatment has a risk of death, brain damage, quadriplegia, paraplegia, the loss of function or loss of an organ or limb, or disfiguring scars, and that I may ask questions concerning such dental treatment.

It is also necessary to have the consent of our patients or a parent/ legal guardian of minors to text or email dental appointment reminders to the patients, or send dental x-rays and/or dental photographs to other dental professionals such as specialists or laboratory technicians. There are risks involved with this, which includes that the message could be read by a third party. The signature below therefore gives the doctor and/or the qualified team of ***Tiger Smile Dental*** permission to text/ email myself reminders or other dental professionals my dental x-rays/ pictures as needed for my individual treatment needs.

Patient Signature (Parent signature if patient is under 18 years of age)

Date