Best Smile Cosmetic Dentistry

500 N. Hiatus Rd. Suite 109 Pembroke Pines, FL 33026 1.954.431.8484 Fax: 1954.431.8435 info@bestmile.us www.bestsmile.us

Patient Information

Thank you for Choosing Best Smile Cosmetic Dentistry for your dental needs. Please complete this form in ink. If you have any question or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________ Date ________ SS/HIC/Patient ID# ________
First Middle Initial Last

Address ______________________ City ____________ State ______ Zip ______

Sex: ❑ Female ❑ Male Birthday ______________ E-mail ______________________

Home Phone ______________ Cell Phone ______________ Work Phone ____________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

Are you:

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced Partnered for ____ years

Patient Employer/School ______________________ Occupation ____________

Employer/School Address ______________ City ____________ State ____ Zip ______

Spouse or parent's Name ________ Employer ______________ Work Phone ____________

Whom may we thank for referring you to us? ______________________________

Person to contact in case of emergency ______________________ Phone ____________

Responsible Party

Name of person responsible this account

Relationship to patient ______________________ Phone ____________

Address ______________________ City ____________ State ____ Zip ______

Name of employer ______________________ Work Phone ____________

Insurance Information

Name of Insured ______________________ Relationship to patient ______________

Birth date ____________ Social Security # ____________ Date employed ____________

Name of employer ______________________ Work Phone ____________

Address ______________________ City ____________ State ____ Zip ______

Insurance Co. ______________________ Group # ____________ Employer # ____________

Insurance Co.Address ______________ City ____________ State ____ Zip ______

How much is your deductible? ________ How much have you used? ________ Max. Annual benefit? ________

Do you have additional insurance? ❑ No ❑ Yes **If yes, Please complete the following:**

Name of Insured ______________________ Relationship to patient ______________

Birthdate ____________ Social Security # ____________ Date employed ____________

Name of employer ______________________ Work Phone ____________

Address ______________________ City ____________ State ____ Zip ______

Insurance Co. ______________________ Group # ____________ Employer # ____________

Insurance Co.Address ______________ City ____________ State ____ Zip ______

How much is your deductible? ________ How much have you used? ________ Max. Annual benefit? ________

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Dental History

Name ______________________ Age ________ Date of last exam ________

First Middle Initial Last

Former Dentist ________________ Date of last dental X-rays ________________

Reason for today's visit ________________

How often do you brush? ________________ How often do you floss ________________

Please check any of the following conditions that apply to you:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping of jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

Medical History

Physician ________________ Date of last exam ________________

Please list all medications you are currently taking: ________________

Allergies: ________________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check box if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ loose teeth or broken fillings
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- Describe ________________
- ❑ Hemophilia
- ❑ Sensitivity to sweets
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Problems
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Sensitivity to sweets
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Have you ever taken any of these medications:

Diet Medications: ❑ Dexfenfluramine ❑ Fen-phen ❑ Pondimin ❑ Redux

Blood Thinners: ❑ Coudamin ❑ Warfarin

Other: ❑ Levoxyl ❑ Synthroid

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

I certify that I, and/or my dependent(s), have insurance coverage with ________________

Name of Insurance Company(ies)

and assign directly to Dr. ________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This Consent will end when my current treatment plan is completed or one year from the date signed below.

________________ ________________

Signature of Patient, Parent, Guardian or Personal Representative Date

________________ ________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office. Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Morning appointments are best for more complicated procedures.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the emergency situation. At some point, they may need the same courtesy too!

Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of $100 per broken appointment or cancellation with less than 24 hours' notice.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

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Patient Signature

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