Global Smiles Dental Registration Form

(Please type or print.)

PATIENT INFORMATION

Last:	First:	M.I.:	Status: Single ☐ Mar ☐	Soc Sec #:

E-Mail:	Driver's License #:	Birthday:	Gender: ☐ M ☐ F

Street address:	Apt #:	City:	State:	ZIP Code:

Home Phone #:	Work Phone #:	Ext:	Cell Phone #:

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? (Please specify):

HEALTH INFORMATION

Date of Last Dental Visit:	Reason for this visit:

Have you ever had any of the following? Please *check* "Yes" or "No" below:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Fainting	☐	☐	Mental Disorders	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Nervous Disorders	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Growths	☐	☐	Pacemaker	☐	☐	Tumors
☐	☐	Artificial Joints	☐	☐	Hay Fever	☐	☐	Pregnancy	☐	☐	Ulcers
☐	☐	Asthma	☐	☐	Head Injuries			Due Date:	☐	☐	Codeine Allergy
☐	☐	Blood Disease	☐	☐	Heart Disease	☐	☐	Radiation Treatment	☐	☐	Penicillin Allergy
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Respiratory Problem	☐	☐	Thyroid Deficiency
☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Rheumatic Fever			OTHER Allergies:
		TYPE: ☐ 1 ☐ 2	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	SULFA Allergy
☐	☐	Dizziness	☐	☐	Jaundice	☐	☐	STD's	☐	☐	LATEX Allergy
☐	☐	Epilepsy	☐	☐	Kidney Disease			TYPE:	☐	☐	PHEN PHEN Allergy
☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Stomach Problems	☐	☐	Other:

Do you smoke? ☐ Yes ☐ No	Please list medications you are taking: ____________________ ____________________
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No	If yes, please explain:
Are you now under the care of a physician? ☐ Yes ☐ No	If yes, please explain:
Physician:	Physician's Phone #:
Do you have any health problems that need further clarification? ☐ Yes ☐ No	If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent, or guardian: Date:

OFFICE USE ONLY, BELOW THIS LINE

Doctor Comments:

____

____

____

Doctor Signature: ____________________

Date: _____ / _____ / _________

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment | Social Security #:

Name: | Relation: Patient ☐ Married to ☐ Child of ☐ Other ☐

Gender: ☐ M ☐ F	Birthday:	Home Phone #:	Work Phone #: ext.	Cell Phone #:

Address:

Street | Apt# | City | State | ZIP Code

EMPLOYMENT INFORMATION

Employer:	Occupation:	Employer Phone #: ext.

Address:

Street | City | State | ZIP Code

INSURANCE INFORMATION

Primary Insurance Company:

Name of Insured:	Birthday:	Is this person a patient here? ☐ Yes ☐ No
ID #:	Group #:	Home Phone #:

Insured's Address (if different):

Street | City | State | ZIP Code

Insured's Employer Name:

Employer's Address (if different):

Street | City | State | ZIP Code

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Secondary Insurance Company:

Name of Insured:	Birthday:	Is this person a patient here? ☐ Yes ☐ No
ID #:	Group #:	Home Phone #:

Insured's Address (if different):

Street | City | State | ZIP Code

Insured's Employer Name:

Employer's Address (if different):

Street | City | State | ZIP Code

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

We record all procedures for security and training purposes ______ Initial

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient, Parent, or Guardian | *Date* | *Relationship to Patient*

Signature of Guarantor of Payment/Responsible Party | *Date* | *Relationship to Patient*