**Patient Information**

(Please Print)

Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name (If different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_ Female \_\_

(Last) (MI) (First)

Marital Status: \_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (Apt#) (City) (State) (Zip)

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_

(Last) (MI) (First)

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_ Female \_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (Apt#) (City) (State) (Zip)

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Information**

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have Insurance? \_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (Suite#) (City) (State) (Zip)

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

(Last) (MI) (First)

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_ Female \_\_

Insured Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (Apt#) (City) (State) (Zip)

Insurance Plan Name and Address and Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Secondary Coverage? \_\_\_\_\_\_\_\_, if so, we will give you the necessary information to assist you in filing for secondary coverage.

**Emergency Information**

In the case of an emergency, who may we contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I affirm the information I have given is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and cannot be released to anyone without my consent. It is my responsibility, as the patient, to notify the office of any changes to my medical status. I authorized Dr. Todd McCracken and his Clinical Auxiliary to perform the necessary dental services to determine my dental and periodontal needs.

Signature (Patient/Parent or Guardian of Minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Office Policies and Payment Conditions** |

|  |
| --- |
| Payment is due at the time of service. We accept cash, checks, and major credit cards. We offer an outside financing option |
| known as Care Credit. A Payment Plan may be utilized in accordance with Office Policies. |

**Insurance**

This office will prepare insurance claims and assist in collecting from your insurance company. All money paid to the office will be credited to the patients account. In the event of an insurance over-payment or the insurance requests to be refunded, we will refund the insurance company. In the event your insurance does requests a refund, the patients account will be charged. This office cannot render services under the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance must understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as a non-covered procedure. This office and its Clinical Team follow the “Standard of Care” set by the State Board of Dental Examiners to assure you the best care possible. At the time of service, our office will estimate your portion based on benefit information given prior to your visit. You will be expected to pay the estimated portion at the time services are rendered. This portion is only an estimate. A statement will be sent every month to keep you aware of your account. After 90 days, you will be responsible for any remaining balance.

**Office Policies**

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

We respect your concern for your loved ones but due to the delicacy of our equipment and other patient privacies we request only the patient be present in the operatory. Additional family members must wait in our reception area.

We value your time and hope you will value ours. Our office reserves the right to charge for broken appointments without a 24 hour notice.

**Authorizations**

I do hereby authorize Laser Smile Studio or Dr. Todd McCracken to release all information necessary to secure the payment of benefits. I authorize the use of this signature on file for all insurance claim submission whether manual or electronic.

I do hereby authorize dental services for my child including, but not limited to, X-rays, treatment and administration of anesthetics deemed necessary or advisable by the Doctor, whether or not I am present at the appointment when treatment is rendered (if applicable, please initial \_\_\_\_\_\_\_\_\_\_\_).

I have read the above office policies and payment conditions and agree to their content. My signature below represents my agreement.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of patient, parent/guardian)

**Patient Health Information**

Are you currently under the care of a Physician? Please explain.

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or had any of the following? Please circle.

Aids Allergies (List) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Blood Disease

Cancer (Specify\_\_\_\_\_\_\_\_\_\_) Diabetes

Dizziness Epilepsy

Excessive Bleeding Fainting

Glaucoma Growths

Hay Fever Head Injuries

Heart Disease Heart Murmur

Hepatitis (Specify \_\_\_\_\_\_\_\_) High Blood Pressure

Jaundice Kidney/Liver Disease

Mental Disorders Nervous Disorders

Pacemaker Pregnancy (Due Date \_\_\_\_\_\_\_\_\_\_\_\_)

Radiation Treatment Respiratory Problems

Rheumatic Fever Rheumatism

Sinus Problems Stomach Problems

Stroke Tuberculosis

Tumors Ulcers

STD (Specify\_\_\_\_\_\_\_\_\_\_\_\_) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any of the following: (Please circle)

Aspirin Penicillin

Codeine Latex

Other drugs allergies : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any of the following:

Aspirin Insulin/Diabetic Drugs

Blood Thinners Tranquilizers

Recreational Drugs Steroids

Please List any prescription drugs you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any complications following dental treatment? (Y) (N) If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Joint Replacement or Heart Valve Replacement? (Y) (N)

Are you currently in dental pain? (Y) (N)

Do you need an Antibiotic Premedication before dental work? (Y) (N)

Do your gums bleed? (Y) (N)

Do you smoke cigarettes? (Y) (N)

Have you been admitted to the hospital or needed emergency care in the past 2 years? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WOMEN ONLY: Are you taking Birth Control? (Y) (N) Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Could you be Pregnant? (Y) (N) (Unsure)

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 Dr. Todd McCracken and his Clinical Team at the next appointment without fail.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Patient or Guardian)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_