

In Case of Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Dental History

Date of Last Dental Visit: _____
Month Date Year

Reason for last dental visit: _____

Health History

Have you ever had any of the following?
Please check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus Problems | |

Other: _____

Are you currently pregnant? Yes No N/A

If yes, what is your due date? _____

Please list any and all medications you are currently taking: _____

Have you ever had complications following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years?

Yes No

If yes, please explain: _____

Are you under the care of a physician now? Yes No

If yes, please explain: _____

Name of Physician: _____

Physician's Phone Number: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Insurance Information

Dental Insurance: Yes No

Name of Insurance: _____

Insured party: _____

*Insured party SSN# or subscriber # _____

*optional (you may call our office at 501-225-0300 to supply your social security number is you prefer)

Insured Employer: _____

Insured Party Date of Birth: _____

Month

Date

Year

Insurance Address: _____

City

State

Zip

Insurance Phone: _____

Insurance policy # or Group #: _____

Please read the following information regarding your insurance and maintaining your account in good standing.

You are required to pay all co-pays, deductibles, and non-covered charges at the time of service. We will file your insurance to have the insurance company pay their part.

All balances are due and payable at 60 days regardless of insurance claim status.

THIS MEANS AFTER 60 DAYS IF YOUR INSURANCE HAS NOT PAID THEIR PART, THE RESPONSIBILITY FOR PAYMENT IN FULL IS YOURS AND YOU CAN DEAL WITH YOUR INSURANCE COMPANY.

We do not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. You are responsible directly to the office for payment of your account within 60 days.

If you have any questions concerning our policies or about your insurance please feel free to ask us, we will be glad to assist you. But please do remember it is your insurance, not ours.

I have read and agree to your insurance policies.

Name: _____

Signature: _____

Date

Please fax this completed form to 501-225-0301. If you have any questions or concerns, please contact us at the number below:

Smiles By Design
Alan Smith, DDS
14000 Cantrell Road, Suite C
Little Rock, AR 72223
501-225-0300 (phone)
501-225-0301 (fax)
www.smilesbydesignonline.com