Smile Ft.Worth

Acquaintance and Health History Record

PATIENT INFORMATION **DATE**_____

LEGAL NAME _____

NAME YOU WISH TO BE CALLED _____ DATE OF BIRTH_____

SOCIAL SECURITY #_____ DRIVERS LICENSE_____

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

IF A MINOR, PARENT OR GUARDIAN NAME _____

STREET ADDRESS _____CITY _____ STATE_____ZIP_____

HOME PHONE (_____) _____ BUSINESS PHONE (_____) _____

CELL (_____) _____ PAGER (_____) _____ E-MAIL _____

Is Another Member of Your Family a Patient? ☐ Yes ☐ No If yes, name _____

Would you like to receive appointment confirmations by:

☐ phone, which number _____ ☐ text message ☐ email message

When was your last dental visit? _____ May we contact that office for your dental records? ☐ Yes ☐ No

If yes, Dentist _____ Phone # _____

Emergency contact name and #: _____

Do you prefer appointments to be scheduled in the ☐ morning ☐ afternoon *(certain procedures must be scheduled at times designated. But some appointments can be scheduled to best fit your preferred times.)*

EMPLOYER & INSURANCE INFORMATION

EMPLOYER _____ OCCUPATION _____

INSURANCE _____ GROUP NO _____

INSURANCE ID# (IF DIFFERENT FROM SSN) _____

If you are not the insured or if you are insured under multiple policies, please complete the following information regarding the insured:

INSURED NAME _____DOB_____ SOC SEC #_____

RELATION TO PATIENT _____ INSURANCE ID# (IF DIFFERENT FROM SSN)_____

ADDRESS (if different from patient) _____

PHONES (H) _____ (W) _____ (C)_____

EMPLOYER _____

INSURANCE _____GROUP NO_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

If you located us on the internet please check one:

☐ **Yellowpages** ☐ **Yelp** ☐ **Google** ☐ **Other**_____

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Drs. Batton, Harlin and/or Wilkinson to make a thorough diagnosis of dental needs.

2. Upon such diagnosis, I authorize Drs. Batton, Harlin and/or Wilkinson to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I understand that this facility provides dental care services without discrimination based on race, religion, color, national origin, sex, sexual orientation, physical or mental disability, age or marital status and protects the privacy of each of its patients.

5. Lastly, I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made in advance with the Financial Coordinator. I understand that I am responsible for the total amount of my dental treatment regardless of my personal insurance benefits. I understand that if I am delinquent on my obligation to pay Smile Fort Worth, then I will be responsible for any late fees, interest charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence.

I certify that I have had an opportunity to read and fully understand the terms and words within the above. I have been encouraged to ask questions

Signature of Responsible Party _____ **Date**_____