Premier Smile Center

7212 Brookfield Road ~ Columbia, SC 29229
803.672.1140

PATIENT REGISTRATION

Date: _____________

Mr./Ms./Mrs.__________________________________ Preferred Name: __________________

Social Security #: ______________________________ Date of Birth: ______________________

Street Address: ____

City: ________________________ State: __________________ Zip: ___________

Home Phone: _____________________________ Cell Phone: _____________________________

Email Address: __________________________________ Referral Source: __________________

If a child, Parent/Guardian's Name: ____

Patient/Parent Employer: _______________________________ Work Phone: ______________

Work Address: ____________________________________ Job Title: ______________________

Circle one: Single Widowed Married Divorced Child

Name of Spouse: ____

Spouse's SSN: ___________________________ DOB: ________________________

Spouse's Employer: ____

Business Address: ____

Business Phone: ____

In case of emergency, who should be notified?

____

____

____

Phone:

____

Who is responsible for this account? ___________________ Relationship to Patient: ____________

Do you have dental insurance? Yes or No

If so, Name of Company: _______________________ Company Phone: _______________________

Subscriber's Name: ____________________________ Relationship of Subscriber: ________________

Subscriber's ID: _________________ Subscriber's SSN: _________________

Subscriber's DOB: _________

****PLEASE NOTE: IF INSURANCE IS ACCEPTED, PATIENT IS RESPONSIBLE FOR CO-PAYMENT PRIOR TO SERVICES****

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MEDICAL HISTORY

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Tetracycline
Y	N	Latex	Y	N	Aspirin
Y	N	Dental Anesthetics	Y	N	Erythromycin
Y	N	Codeine	Y	N	Other

Please list any other drugs that you are allergic to: ____

____

Your current physical health is: ❑ **Good** ❑**Fair** ❑ **Poor**

Are you currently under the care of a physician? ❑No ❑Yes

Please explain: ____

____

Physician's Name: ___________________________________ Office Number: _______________________

Are you taking any prescription/over-the-counter drugs? ❑No ❑Yes

____

For Women:

Are you taking birth control? ❑No ❑Yes

Are you pregnant? ❑No ❑Yes Week# ______

Are you nursing? ❑No ❑Yes

Tell us about your smile:

Y N Are you in pain?

Y N Do your gums bleed while brushing or flossing?

Y N Are you brushing/flossing twice a day?

If you could change anything about your smile, what would it be?

____

____

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MEDICAL HISTORY cont...

Have you ever had any of the following diseases or medical problems?

Y	N	Stroke	Y	N	Heart Attack
Y	N	Cancer/Chemotherapy	Y	N	Heart Murmur
Y	N	Rheumatic Fever	Y	N	HIV+/AIDS
Y	N	Heart Surgery	Y	N	Shingles
Y	N	Mitral Valve Prolapse	Y	N	Kidney Problems
Y	N	Artificial Bones	Y	N	Artificial Valves
Y	N	Sinus Problems	Y	N	High/Low Blood Pressure
Y	N	Fever Blisters	Y	N	Severe/Frequent Headaches
Y	N	Emphysema	Y	N	Glaucoma
Y	N	Psychiatric Problems	Y	N	Epilepsy
Y	N	Seizures	Y	N	Fainting Spells
Y	N	Diabetes	Y	N	Tuberculosis (TB)
Y	N	Drug/ Alcohol Abuse	Y	N	Venereal Disease
Y	N	Hemophilia/ Abnormal Bleeding	Y	N	Ulcers/Colitis
Y	N	Anemia	Y	N	Radiation Treatment
Y	N	Asthma	Y	N	Difficulty Breathing
Y	N	Hospitalized for any reason	Y	N	Hepatitis
Y	N	Blood Transfusion	Y	N	Gum Disease

Please list All serious medical condition(s) that:

____

____

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature   Date

****PAYMENT IS DUE IN FULL AT TIME OF TREATMENT****

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, please us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I have reviewed the patient registration information above and I understand that I am responsible for the cost of all dental treatment. I further understand that if I do not give a 24-hour cancellation notice each time a scheduled appoint is cancelled, I will be charged **$25.00**.

Signature of Patient   Date

I hereby authorize payment of group insurance benefits, otherwise payable to me, directly to Premier Smile Center.

Signature of Patient   Date

I hereby authorize Premier Smile Center to use my photographs for marketing/advertising purposes in digital and print.

Signature of Patient   Date