**NAME: (FIRST) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(LAST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MIDDLE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(MAILING ADDRESS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(PARISH): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (POSTAL CODE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MARITAL STATUS):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(GENDER): M / F (CIRCLE ONE) (DATE OF BIRTH): (D/M/YR) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT INFORMATION:**

**(HOME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WORK) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(CELL )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(EMAIL) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT PERSON:**

**(NAME): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (RELATIONSHIP):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(HOME PHONE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (CELL/WORK): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE DENTAL INSURANCE? YES / NO - IF YES PLEASE GIVE INSURANCE CARD TO RECEPTIONIST FOR SCANNING**

**(NAME OF INSURED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DATE OF BIRTH OF INSURED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(EMPLOYER OF INSURED):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

FINANCIAL AGREEMENT:

I, the undersigned, certify that I (or my dependent) have insurance benefits with my insurance company, and when warranted, assign directly to Smiles Inc. I understand that I am financially responsible for all charges not paid by insurance, and that all unpaid accounts are sent to Bermuda Credit Association. I hereby authorize Smiles Inc. to release all information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions.

(SIGNATURE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DATE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS: YES / NO (circle one) REASON:**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |

**ALLERGIES: YES / NO (circle one)**

|  |  |
| --- | --- |
| * **ASPIRIN** | * **LOCAL ANESTHETIC** |
| * **CODEINE** | * **PENICILLIN** |
| * **IODINE** | * **SULFA** |
| * **LATEX** | * **OTHER (PLEASE LIST)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **YES** | **NO** |  | **YES** | **NO** |  |
|  |  | **HIV/AIDS** |  |  | **HERPES/COLD SORES** |
|  |  | **ARTHRITIS** |  |  | **HIGH BLOOD PRESSURE** |
|  |  | **RHEUMATISM** |  |  | **LOW BLOOD PRESSURE** |
|  |  | **ARTIFICIAL HEART VALVES** |  |  | **KIDNEY DISEASE** |
|  |  | **ARTIFICIAL JOINTS** |  |  | **LIVER DISEASE** |
|  |  | **ASTHMA** |  |  | **MITRAL VALVE PROLAPSE** |
|  |  | **BACK PROBLEMS** |  |  | **OSTEOPOROSIS** |
|  |  | **BLEEDING ABNORMALLY (DURING SURGERY)** |  |  | **PACEMAKER** |
|  |  | **CANCER** |  |  | **PSYCHIATRIC CARE** |
|  |  | **COUGH (BLOODY/PERSISTANT)** |  |  | **RADIATION TREATMENT** |
|  |  | **PREGNANT** |  |  | **RESPIRATORY DISEASE** |
|  |  | **DIABETES TYPE \_\_\_\_\_\_** |  |  | **RHEUMATIC/SCARLET FEVER** |
|  |  | **EMPHYSEMA** |  |  | **SEIZURES** |
|  |  | **EPILEPSY** |  |  | **SHORTNESS OF BREATH** |
|  |  | **GLAUCOMA** |  |  | **SINUS TROUBLE** |
|  |  | **HEADACHES** |  |  | **STROKE** |
|  |  | **HEART ATTACK** |  |  | **THYROID PROBLEMS** |
|  |  | **HEART MURMUR** |  |  | **TUBERCULOSIS** |
|  |  | **HEPATITIS TYPE \_\_\_\_\_** |  |  | **OTHER** |

**NEW PATIENTS ONLY:**

**LAST DENTAL APPOINTMENT IF NEW PATIENT (APPROXIMATE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRAL DENTIST: (IF YOU HAVE BEEN SENT TO US BY YOUR REGULAR DENTIST): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTAL TREATMENT CONSENT**

**I have provided an up-to-date medical history as listed above, and I will inform Smiles Inc of any changes to my medical history at subsequent visits. I consent to x-rays, anesthetic, dental/surgical treatment as prescribed by a dental professional.**

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