Michael A. Smith, DDS, MS

Practice Limited to Endodontics

Thank you for contacting our office, and welcome to our practice. Our goal is to make your visit here as comfortable as possible. Please complete the following registration forms and bring them with you to your appointment.*

In addition, please follow these guidelines in preparation for your visit:

1.) Please bring your referral information and x-rays, if any, from your restorative dentist.
2.) Eat breakfast or lunch before your appointment to ensure a normal blood glucose level.
3.) Please arrive 10 minutes early to complete a few additional forms. Bring a complete list of all medications and dosages with you.
4.) Take your routine medications, including aspirin therapy, if applicable. However, do not take medication for discomfort (i.e. Advil, etc.) prior to a consultation visit as it may mask symptoms and hinder diagnosis.
5.) If you require **prophylactic antibiotics** before dental visits for certain heart conditions, prosthetic heart valve or orthopedic prosthesis (artificial hip, knee, elbow, etc.), please call our office for instructions. If you've already discussed this with us, you do not need to call again.
6.) At times, last minute emergency patients can cause delays. We value your time and will try to keep you updated when delays occur. *However, please adjust your schedule to allow some extra time.*
7.) All patients under the age of 18 must be accompanied on each visit by their parent or legal guardian.
8.) Feel free to explore our website at www.msmithendo.com as it contains information you may find helpful.

If for any reason you cannot keep this appointment, please call our office at least 48 hours in advance. There will be a charge for a missed appointment.

We look forward to being of service to you. If you have any questions, please don't hesitate to call us.

Sincerely,

Dr. Michael A. Smith and Staff

*Completion of these forms does not constitute the establishment of a doctor-patient relationship.

MEDICAL HISTORY

PATIENT NAME_____

Are you in good health?_____

Are you presently under the care of a physician?_____

If so, please give the reason(s) for treatment _____

_____

Physician's name:_____ **Telephone**:_____

Date of last Physical exam:_____

Are you taking any kind of medication (prescribed or non-prescribed) at this time?_____

If so, please give the name(s) of the medicine(s) and the reason(s) for taking them:

_____

_____

_____

CIRCLE ANY ILLNESS or CONDITION YOU HAVE OR HAVE EVER HAD:

Alcoholism	Cancer	Head/Neck Injuries	Narcotic/Drug Dependency	
Allergies	Diabetes	Herpes	Rheumatic Fever	
Anemia	Epilepsy	Hepatitis	Shingles	TMJ
Asthma	Emphysema	Immunodeficiency	Sinusitis	Ulcers
Arthritis	Heart Murmur	Kidney or Liver	Stroke	Other
Angina	Heart trouble	Mental	STD	
Blood pressure	HIV/AIDS	Migraine	Thyroid	

Explanation of "Other"_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Latex	Penicillin	Other Antibiotics	Aspirin/Ibuprofen	Sedatives
Bleach	Local Anesthetic	List other allergies:_____		

Do you take insulin?_____

Do you take blood thinning medication?_____

Have you ever had any trouble with prolonged bleeding after surgery? _____

Are you currently taking or have you previously taken bisphosphonate medications such as Fosamax, Actonel, Zometa or Boniva within the past twelve years?_____

Do you have a heart pacemaker or any other kind of prosthetic appliance?_____

Is there any other information that should be known about your health?_____

_____

Any problems with previous dental visits? _____

If female, are you pregnant? _____

Have you had previous endodontic (root canal) treatment? _____If so, when?_____

Doctor's name: _____

Comments:_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing false information can be dangerous to my health. I authorize the release of any information including diagnosis and treatment records rendered to me or my dependant to a third party payee and/or healthcare practitioners necessary to process dental insurance. I authorize my insurance carrier to issue payment directly to this office.

Signed PATIENT or PARENT _____Date: _____

(Michael A. Smith, DDS, MS Revised 8/2011) CONFIDENTIAL for Record and Evaluation

ACCOUNT INFORMATION

Patient Information

Patient's Name _____

Street Address:_____City:_____State:_____Zip:_____

Mailing Address_____

Home Phone _____ Work Phone_____Ext#_____

Social Security # _____ Birthdate _____

Employer_____ Occupation _____ No. years Employed _____

Who may we thank for referring you to our office?_____

Person Responsible for Account (If Patient is Under 18)

Name _____ Birthdate _____ Social Security # _____

Address_____

Emergency Information

Name of nearest relative not living with you _____

Complete Address:_____

Phone:

Dental Insurance Information

Insured's Name _____Insured's Social Security # _____

Insurance Company _____ Group No._____ Employer _____

Insurance Co. Address_____

Do you have dual coverage? Yes No *How long has this policy been in effect?* _____

Insured's Name _____Insured's Social Security # _____

Insurance Company _____ Group No._____ Local No. _____

Insurance Co. Address_____

Insured's Employer _____

Method of Payment

Fees and estimated co-payments must be paid in full at the time of treatment. **Which of the following methods of payment you will be using?**

Cash Check VISA MC Discover/AMEX CareCredit

All information written is true and complete. The undersigned agrees to be responsible for all fees (and co-payments) for services rendered in this office for me or my dependents.

SIGNATURE_____**DATE**_____

If dental insurance applies: Although this office files insurance claims as a service to the patient, we are not a participating provider with any insurance company. The insurance contract is between the patient and the insurance company. PLEASE NOTE THAT CO-PAYMENTS COLLECTED AT THE TIME OF SERVICE ARE ESTIMATES ONLY AND NOT A GUARANTEE OF PAYMENT. As we have no control over the insurance company's method or amount of payment, any difference of payment is entirely the responsibility of the patient.

SIGNATURE_____ **DATE** _____

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