SINGH SMILE CARE
COSMETIC AND IMPLANT DENTISTRY

Medical Alert For Office Use

Thank you for visiting Singh Smile Care. We want your visit to be pleasant and comfortable. Please help us by updating your information and medical history.

Patient Information (Update)

Today's Date:_____ Date of birth_____

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____ Apartment #: _____
STREET

_____
CITY STATE ZIP

Employer _____ E-mail: _____

Phone: Home (____) _____ Full Social Security #: _____

Work (____) _____ May we contact you at work? ❑ Yes ❑ No

Mobile(____) _____ ❑ Male ❑ Female

Emergency: Name _____ Phone (____) _____

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Acid Reflux
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Anxiety/Panic Attacks
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer-Type:
  Diagnosed when:_____
  Active: Y or N
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV or Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
  Type:_____
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Organ Transplant:
  Type:_____
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ STD
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other _____

_____

Y	N	
❑	❑	Do you Smoke/Vape/ Use Tobacco?
❑	❑	Do you have a Family History of Diabetes?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? _____ If yes, # of weeks:_____
❑	❑	Are you Nursing?

Please list any medications including over the counter, medicinal, vitamins) and what it's for:_____

_____

_____

Are you currently under physicians care? (Cardiologist, Organ, OBGYN, Orthopedic etc): Y____ N_____

Doctor / Surgeon Name:_____
Doctor/Surgeon Phone Number:_____ **What For:**_____

Doctor / Surgeon Name:_____
Doctor/Surgeon Phone Number:_____ **What For:**_____

List all surgeries and dates:_____
_____
_____

I certify to the above statements regarding my medical condition. It is my responsibility to inform the office of any changes of the information provided on this form.

Patient Signature:_____ **Date:**_____

CANCELLATION POLICY

We make every effort to schedule out patients with the appropriate amount of time for their treatment and to see them on time. We expect the same effort from our patients in making it to their scheduled appointments. *****Policy requires that our patients provide at least 48 business hours when needing to cancel an appointment. Failure to provide such short notice may result in a $75 per hour missed "cancellation" fee. If you are more than 15 minutes late to your appointment, we may have to reschedule you and there will be a $75 per hour charge*****

Although rarely an issue, patients that do not show for three consecutive appointments may be discharged from the practice. I have read and understand the cancellation policy.

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize Singh Smile Care to release any information including the diagnosis, radiographs and treatment notes rendered me during the period of medical / dental care of third party payers (insurance) and / or health practitioners.

I authorize and hereby request my insurance company to pay directly to Singh Smile Care insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered on my behalf or the behalf of my dependents, leaving me responsible.

If I do not pay the entire balance within 90 days of the monthly billing date, a billing fee of 1.5% per month will be charged on the balance owed. I realize that failure to keep my account current will result in Singh Smile Care being unable to provide additional medical / dental services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balance.

*****PLEASE NOTE*** As a courtesy to you, we will file insurance on your behalf and estimate your portion that is due and payable at the time of service based on the information your insurance gives us during our information gathering on your specific plan. It is your responsibility to provide us with correct, current insurance information and see that your insurance company pays in a timely manner. All estimates are just estimates. We do not do pre-authorizations as it is not a guaranteed payment from your insurance. Final balance due will not be confirmed until after your insurance pays on your completed treatment. Please be aware that after insurance pays for your treatment, most insurances have up to 2 years to perform an audit and request a refund in which you will owe them or us the money based on who your insurance requests it from.**

Patient Signature:_____ **Date:**_____

Patient Printed Name:_____

If Patient is Under 18

Responsible Party:_____ **Relation to Patient:**_____

Responsible Printed Name:_____