

Welcome to Smile Loft Branch Ave!
So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.



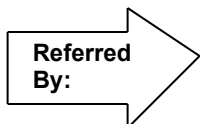
Today's Date _____ Male _____ Female _____ Marital Status _____
 Name _____ Date of Birth _____
 Address _____ Apt. No. _____
 City _____ State _____ Zip Code _____
 Home Phone No. _____ Work Phone No. _____
 Cell Phone/Pager _____ Email Address _____
 (if you want to be contacted this way)
 Social Security No. _____ Driver's License No. _____
 Person to contact in case of emergency _____



Name _____ Relationship to Patient _____
 Address _____ City, State, Zip Code _____
 (if different from above)
 Home Phone No. _____ Work Phone No. _____
 Social Security No. _____ Driver's License No. _____



Employee Name _____ Employer Name _____
 Insurance Co. _____ Group No. _____
 Employee Date of Birth _____ Employee Social Security No. _____



Who may we thank for referring you to our office:

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, 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.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon date, I understand that a 1.5% late charge (18% APR) and any expenses such as attorney fees if engaged for the purpose of collection may be added to my account.

Patient or Responsible Party _____ Date _____