U.P. Superior Smiles (906) 630-6197
4234 I-75 Bus Spur #218 SSM MI 49783 – Urgent Care Line (231) 437-4751

Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #:_____ Birth Date: _____

Phone (Home):_____ (Work):_____ Email address_____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact #_____

I give consent for U.P. Superior Smiles to take and use my picture for educational and promotional purposes. If yes please initial_____

Health Information

Date of Last Dental Visit:_____ Reason for this visit:_____

Blood Pressure_____/_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
- ☐ Penicillin Allergy
- ☐ Sulfur
- ☐ Latex Allergy
- ☐ Pine Sap Allergy
- ☐ Tree Nut Allergy
- ☐ Codeine Allergy

_____

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:
☐ _____

Tobacco Use:
Yes____No_____

- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list:_____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician:_____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Race

☐ White ☐ Black/African American ☐ Hispanic ☐ Latino ☐ Arabic ☐ Asian ☐ Native American ☐ Hawaiian
☐ Other _____

Ethnicity

☐ Hispanic ☐ Non-Hispanic

Language

☐ English ☐ Hispanic ☐ Arabic ☐ Asian ☐ Other _____

☐ ☐

Employment Information

The following is for: the patient the person responsible for payment

Employer Name:_____ Occupation: _____

Address: _____ ☐ ☐
Street City State Zip Code

Responsible Party / Insurance Information

Primary

Name of Insured:_____ Is insured the patient? Yes No
Last First MI

Insured's Birth Date:____/____/____ SSN:_____ ID #:_____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Financial Agreement and Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

There is no assurance of success that has been or can be given in dental treatment. There is always the possibility that further treatment may be necessary which may result in additional charges. In signing below, you acknowledge full responsibility for the payment of all necessary services on the date treatment is started.

I understand that specific amount of time is allotted for my visit each time I schedule and the terms for cancellation have been explained to me. I understand if I need to cancel my appointment, I need to inform the office with 24-hour notice.

U.P. Superior Smiles include Fluoride Treatments, Oral Health Education, Pit and Fissure Sealants, Prophylaxis, Silver Diamine Fluoride, Screening, Nutritional Counseling and Tobacco Cessation Counseling. These services may be obtained at the patient's dental home rather than by the PA 161 Program. Obtaining services from different offices may affect insurance benefits from private insurance companies, state and federal programs, or third-party provider benefits.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party