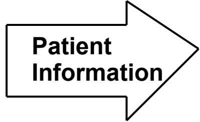
SMILE LOFT
GLEN BURNIE

Welcome to Smile Loft Glen Burnie!
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.

Registration Form



Today's Date ______________________________ Male ______ Female ______ Marital Status ____________

Name ____ Date of Birth __________________________

Address ____ Apt. No. __________

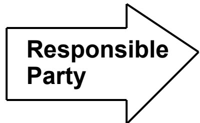
City ______________________________________ State ____________________ Zip Code _____________

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)

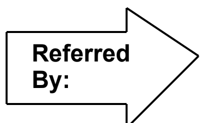
Home Phone No. _________________________________ Work Phone No. ___________________________

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:

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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 ____________________________