#_____

Welcome to Trading Smiles!

Please follow these directions:

1. Completely fill out the registration forms.

2. Choose the procedure you want and circle on the 2nd page of registration forms.
   I. Extraction
   II. Filling
   III. Hygiene cleaning

3. Give completed forms to front desk, along with Driver's License or Photo ID.

4. Number on your ticket will match number on your registration forms.

5. Stay in reception area until your name/number is called.

Patients will be called upon completion and entry of your registration forms. The hygienists will see all cleaning requests and doctors/assistants will see filling and extraction requests, so **NUMBERS MAY NOT BE CALLED IN ORDER**.

Thank you.

#_____

Registration Form

Date: 5/2/15

Patient Name:_____ Date of Birth:_____

Address:_____ SS#:_____

_____ Phone:_____

Guardian/Parent (if patient is a minor) _____

Do you have or had you ever had:

Artificial Heart Valves	YES	NO	Hepatitis	YES	NO
Artificial Joint/Replacement	YES	NO	High Blood Pressure	YES	NO
Bacterial Endocarditis	YES	NO	HIV/AIDS	YES	NO
Bleeding Problems	YES	NO	Kidney Problems	YES	NO
Cancer or Tumors	YES	NO	Liver Problems	YES	NO
Chemotherapy/Radiation	YES	NO	Osteoporosis	YES	NO
Diabetes	YES	NO	Respiratory Problems	YES	NO
Fainting/Seizures/Epilepsy	YES	NO	Stroke	YES	NO
Heart Attack	YES	NO	Thyroid Problems	YES	NO
Heart Surgery/Stint/Pacemaker	YES	NO	Tuberculosis (TB)	YES	NO

Are you **allergic** to any drugs or medications? If so, please list:

_____

Any **surgeries or hospitalizations**? If so, please list:

_____

Any other physical conditions we should be know about, please list:

_____

_____

Has a Cardiologist, Surgeon, or other Doctor ever told you to take Premed before any dental treatment? YES NO If Yes, what Premed do you take? _____

#_____

Informed Consent

I authorize the doctors at Shreveport-Bossier Family Dental Care and/or designated staff to perform any services necessary to diagnose myself or my dependent's dental needs. Upon such diagnosis, I authorize the doctors at Shreveport-Bossier Family Dental Care and/or designated staff to perform all recommended treatment mutually agreed upon by me. I understand that the use of anesthetics sometimes involves risks, and that I can ask for a complete recital of these risks.

I understand that any an all treatment or services performed or diagnosed by the doctors at Shreveport-Bossier Family Dental Care and/or his designated staff on today's date, May 2rd, 2015, for Trading Smiles is free of charge and comes with no warranties whatsoever either expressed or implied.

_____ _____

Patient or Guardian Signature Date

_____

Patient Name

Procedure I want is: **(Circle One)**

Extraction Filling Hygiene Cleaning

YOU MUST READ AND SIGN CONSENT BEFORE TREATMENT

#_____

Photo Release

I hereby grant Shreveport-Bossier Family Dental Care permission to use my likeness in a photograph or other digital reproduction in any and all of its publications or advertisements, including website entries or phonebook ads, and without payment or any other consideration.

I understand and agree that these materials will become the property of Shreveport-Bossier Family Dental Care and will not be returned. I hereby irrevocably authorize Shreveport-Bossier Family Dental Care to edit, alter, copy, exhibit, publish or distribute this photo for purposes of advertising or marketing, or for any other lawful purpose.

In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

_____ _____

Patient or Guardian Signature Date

_____

Patient Name
Patient Name