Smiles Dental P.C.

Patient Information

First Name Last Name

Patient Name: _____ Preferred Name: _____

Gender: Male: ☐ Female: ☐ Family Status: Married: ☐ Single: ☐ Child: ☐ Other: ☐

Birth Date: _____ SS# _____ E-mail:_____

Home phone Number: _____Work: _____ Mobile: _____

Address: _____City: _____ State: _____Zip Code: _____

Name of source referring you to our practice: _____

Parent, Spouse or Responsible Party Information

Name: _____Relationship: _____

Gender: Male: ☐ Female: ☐ Birth Date: _____ E-mail:_____

Home Phone Number: _____Work:_____ Mobile: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employment Information

The following is for Patient: _____The person responsible for payment: _____

Employer Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Information

Name of Insured: _____Birth Date: _____

ID#: _____Group #: _____ Patient's relationship Self: ☐ Spouse: ☐ Child: ☐ other: ☐

Insured's Employer Name: _____

Employer Address: _____City: _____ State: _____ Zip Code: _____

Insurance Plan Name: _____

Insurance Address: _____

City: _____State: _____ Zip Code: _____

Consent for Services

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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.

A service charge of 1% per month (16% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice. I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

HIPAA CONSENT FORM

I give Smiles Dental P.C. my consent to use or disclose my Protected Health Information to carry out my treatment to obtain payment from insured companies and for health care operations like quality reviews.

I have been informed that I may review the practical clinic's Notice of Privacy Act before signing this consent.

I understand that Smiles Dental P.C. has the right to change their privacy practice and I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my Protected Health Information is used. However, I also understand that Smiles Dental P.C. is not required to agree to the request.

If the clinic agrees to my requested restriction they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing except for information already used or disclosed.

Signature of patient, parent, or guardian (responsible party);

Signature: _____ Date: _____

Relationship to patient: _____

Medical History

Would you consider yourself to be in fairly good health? Yes:☐ No:☐

Within the past year, have there been any changes in your general health? Yes:☐ No:☐

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician:_____

Please mark any of the following to indicate YES in response to the question:

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain_____

Please indicate if you have experienced any of the following:

☐ Pre-Med Amox	☐ Pre-Med Clind	☐ Pre-Med Other	☐ Allergies
☐ Allergy-Aspirin	☐ Allergy Codeine	☐ Allergy Erythro	☐ Allergy Hay Fever
☐ Allergy- Latex	☐ Allergy- Other	☐ Allergy- Penicillin	☐ Allergy Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Blood Thinners	☐ Cancer	☐ Diabetes
☐ Dialysis	☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High blood pressure	☐ HIV
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ other	☐ Pacemaker	☐ Pregnancy Due date: _____
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	

Artificial Joint(s) history: List what joints and date of surgery_____

Cancer history: Please list what type, date(s), treatment mode (ie. Radiation, chemotherapy)

_____

Are your or have you ever undergone treatment for osteoporosis? ☐ Yes ☐ No
Please list the medications you take for osteoporosis and their form (ie. IV or pill):

_____

Are you or have you been addicted to a chemical substance? ☐ Yes ☐ No

Please specify:

☐ Alcohol ☐ Methamphetamine ☐ Prescription Pain Medications ☐ Heroine/Cocaine ☐ Other: _____

Are you undergoing treatment for your addiction? ☐ Yes ☐ No

Do you have any other health issues or allergies that we have not mentioned?

_____

Please list all current PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS you are taking:

Name of Medication	Dosage	When you take it	Why you take it
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dental History

Why are you seeking dental care?

_____

What was done at your last dental visit (if to a different office)?

_____

Date of last dental exam: _____

Previous Dentist's name and address_____

How frequently do you brush your teeth? ☐ 2-3 a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth? ☐ 1 (+) a day ☐ 1-2 times a week ☐ Seldom ☐ Never

Please mark any of the following to indicate YES in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to hot or cold temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth becoming loose?

☐ Have you noticed any lumps or sores in your mouth?

☐ Are you allergic to any metal or dental materials?

☐ Have you ever injured your face, jaws, or teeth?

☐ Do you suffer from pain in the mouth, face, eyes, neck or throat?

If any of the previous questions are marked, please explain:

_____

Do you currently have any dental implants, dentures, or partials? ☐ Yes ☐ No

If yes, please explain:

_____

Has fear ever prevented you from seeking dental treatment? ☐ Yes ☐ No

If yes, please explain:_____

Have you ever had complications following dental treatment? ☐ Yes ☐ No

_____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any),

Please note our office policy requires you to give us a 24 hr notification for any cancellation or re-scheduling of appointments. Unconfirmed appointments will not be reserved. Failure to notify us will result in a penalty.

Signature of patient, parent, guardian, or Power of Attorney: _____Date: _____

Relationship to Patient: _____