Smile Studio
DENTAL

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

1 Patient Information

Today's Date _____

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Address _____

_____

Home # _____ Cell # _____

Employer _____ Work # _____

Occupation _____

Email _____

Referred by _____

Emergency Contact Name: _____

Emergency Contact Phone # _____

2 Responsible Party

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

Employer _____ Work # _____

Occupation _____

Employer's Address _____

_____

3 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employer _____

Employee's Address _____

_____

Orthodontic Coverage? ◯ Yes ◯ No

4 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employee _____

Employee's Address _____

_____

Orthodontic Coverage? ◯ Yes ◯ No

5 Dental History

Purpose of today's visit _____

Previous Dentist _____

Date of last visit _____

What was done _____

Last Cleaning _____

How often do you brush _____ Gums bleed ◯ Yes ◯ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken fillings

☐ Jaw pain ☐ Injuries to teeth

Explain _____

Unpleasant Dental Experience ◯ Yes ◯ No

Explain _____

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Implants

☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers

Are you happy with the appearance of your teeth?

◯ Yes ◯ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ◯ Yes ◯ No

☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ◯ Yes ◯ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ◯ Yes ◯ No

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with _____. I understand that using anesthetic agents embodies a certain
(NAME OF PATIENT)
risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed to provide recommended treatment.

6 Medical History

Physicians Name _____

Office Address _____

_____

Telephone _____

Are you currently under the care of a physician? ◯ Yes ◯ No

Explain _____

Has there been a recent change in your health? ◯ Yes ◯ No

Explain _____

Are you currently taking any prescription, over the counter or recreational drugs? ◯ Yes ◯ No

Explain _____

_____

_____

_____

Have you been hospitalized or had a serious illness within the past five years? ◯ Yes ◯ No

Explain _____

Have you been treated now or in past with Bisphosphonates for Osteoporosis or cancer? ◯ Yes ◯ No

Explain _____

Are you Pregnant or is it likely that you could be pregnant at this time? ◯ Yes ◯ No

Explain _____

Do you?

- ☐ Smoke Packs per day?_____ How long?_____
- ☐ Chew Tobacco
- ☐ Drink Per week? _____Per Month?_____
- ☐ Wear Contact Lenses
- ☐ Take Diet Pills
- ☐ Take Herbal Supplements

Mark if you have or ever had

Y	N		Y	N	
◯	◯	Artificial Limb/joint/hip	◯	◯	Chronic Diarrhea
◯	◯	High/low Blood Pressure	◯	◯	Stoke TIA
◯	◯	Organ Transplant	◯	◯	Joint Surgery
◯	◯	Sinus Problems	◯	◯	Cancer/Chemotherapy
◯	◯	Migraines	◯	◯	Blood Disorder
◯	◯	Frequent Headaches	◯	◯	Increased Frequent
◯	◯	Claustrophobia	◯	◯	Urination
◯	◯	Artificial Heart Valve	◯	◯	Bells Palsy
◯	◯	Prolonged Bleeding	◯	◯	Heart Disease
◯	◯	Ulcers/colitis	◯	◯	Diabetes
◯	◯	Hay Fever	◯	◯	Asthma
◯	◯	Head injury	◯	◯	Night Sweat
◯	◯	Venereal Disease	◯	◯	Psychiatric/Emotional
◯	◯	Mitral Valve Prolapse	◯	◯	Recurrent Infections
◯	◯	Acid Reflux	◯	◯	Angina
◯	◯	Arthritis	◯	◯	Kidney Problems
◯	◯	Epilepsy/seizures	◯	◯	Bronchitis
◯	◯	STD	◯	◯	Addictions
◯	◯	Rheumatic Fever	◯	◯	Pace Maker
◯	◯	Radiation Therapy	◯	◯	Liver Problems
◯	◯	Stomach Problems	◯	◯	Emphysema
◯	◯	Glaucoma	◯	◯	TMJ Problems Shortness
◯	◯	Dizziness/Fainting spells	◯	◯	of Breath Hepatitis: A
◯	◯	Treated for AIDS,HIV, ARC	◯	◯	or B or C Tuberculosis
◯	◯	Heart Murmur	◯	◯	Unexplained Weight
◯	◯	Thyroid Problems	◯	◯	Loss Mouth Ulcers
◯	◯	Used Diet Drug Fen-Phen	◯	◯	Aspirin Daily
◯	◯	Anemia			

Please mark any allergies/adverse reactions :

◯	◯	Penicillin	◯	◯	Aspirin
◯	◯	Tetracycline	◯	◯	Valium
◯	◯	Erythromycin	◯	◯	Barbiturates
◯	◯	Sulfa	◯	◯	Latex
◯	◯	Local Anesthetics	◯	◯	Iodine
◯	◯	Codeine	◯	◯	Household
◯	◯	NSAID (Advil/Motrin)	◯	◯	Bleach
◯	◯	Gluten			

Other _____

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Dentist Signature Date

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

Phone Number E-mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

	Y	N
Send a recall appointment reminder to your home?	○	○
Leave appointment, billing or dental information on your answering machine/voice mail/e-mail:	○	○

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Patient / Parent or Legal Guardian refused to sign form
- ☐ Other

_____

Signature of Office Manager Date

Financial Policy

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)
Legal fees for collection services

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Witnessed By