

PATIENT/INSURANCE/HEALTH HISTORY INFORMATION



Patient Name: _____

Patient Date of Birth: _____ Patient Soc. Sec. #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____ Email: _____

Dental Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber SS/ID #: _____

Whom may we thank for referring you? _____

How would you like your appointments confirmed? Check all that apply. Phone Text Email Postcard

Are you required to Pre-Med before a dental appointment? Yes No

Any allergies? Latex Penicillin Codeine Acrylic Tetracycline Aspirin Metals Dental Anesthetics Foods None Listed

Other: _____

What medications are you currently taking? _____

Have you ever taken: Bisphosphonates Yes No Phen-fen/Redux Yes No

Do you have or have you had any of the following diseases, medical conditions, surgeries or procedures?

<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Congenital Heart Defect/Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Recent Blood Transfusion
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes/Hypoglycemia	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Angina/Chest Pains	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Arthritis/Gout/Rheumatism	<input type="checkbox"/> Emphysema/Lung Disease	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Valves/Bones/Joints	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Thirst/Dry Mouth	<input type="checkbox"/> HIV+/AIDS/ARC	<input type="checkbox"/> Sinus Problems/Hay Fever
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Jaw Problems TMJ/TMD	<input type="checkbox"/> Stomach/Intestinal Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chemotherapy/Radiation Treatment	<input type="checkbox"/> Frequent/Severe Headaches	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Tuberculosis TB
<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> NONE OF THE ABOVE

Other: _____

Do you use tobacco? Yes No If so, how used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? Yes No

For women: Are you taking birth control pills? Yes No How many children have you had? _____

Are you pregnant? Yes No If yes, how far along? _____ Are you nursing? Yes No

Check all that interest you... Teeth Whitening Braces Invisalign Extensive Oral Cancer Screening

Sleep Apnea/Snoring Device Other: _____

*We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interested charges and any other expenses incurred in collecting your account.

* I authorize the staff to perform and necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

* I understand the above information and guarantee this form was completed and update correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Comments/Updates: _____

Signature of Patient/Guardian	Date	Signature of Patient/Guardian	Date
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

the smile

PRIVACY PRACTICES, APPOINTMENTS & FINANCIAL INFORMATION

Patient's Name: _____ Date of Birth: _____

We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.

APPOINTMENTS

- We understand that a missed appointment can happen, but we greatly appreciate consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. This allows us the opportunity to offer that appointment to another patient who needs to see the doctor. If you fail to give at least a 24-hour notice of cancellation on multiple occasions, depending on your insurance company's policies, you will be charged a No Call No Show fee or we will not be able to schedule you for future appointments.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.

FINANCIAL

- Our policy requires payment (or estimated payment if you have insurance) in full, for all services rendered, at the time of visit, unless other arrangements have been made with our business manager.
- For your convenience, we accept: Visa, MasterCard, Discover and American Express, in addition to cash, personal check and Care Credit.
- If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account balance.

INSURANCE

- I authorize this *The Smile dental office* to release any information required to process insurance claims.
- Dental Insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. Insurance companies can take up to 90 days for claims to be paid. It is the responsibility of the patient/guardian to be aware of their plan limitations and waiting periods.
- We assume no responsibility for what your insurance carrier will or will not pay. Please understand that there are many different benefit packages offered by numerous insurance companies and we cannot possibly know the details of each one. We will provide you with an 'estimated co-payment' amount at the time services are rendered, however any remaining balance after your insurance company has paid, will be the responsibility of the patient/guardian.
- Our office is committed to providing the best treatment for you, regardless of insurance coverage. Our treatment and fees remain the same whether a patient has insurance or not and we want to be flexible in these changing times and will do our best to make this work for everyone.

I understand the above information and guarantee this form was completed and update correctly to the best of my knowledge and understand that it is my responsibility to inform this *The Smile dental office* of any changes to the information I have provided.

~HIPAA ACKNOWLEDGMENT~

- I have received or declined a copy of the Notice of Privacy Practices for this The Smile dental office.
- I have read and agree with the policies stated below for this The Smile dental office.

Patient/Guardian Signature: _____ Today's Date: _____

~FOR OFFICE USE ONLY~

We attempted to obtain written acknowledgment but could not be obtained because:

- | | |
|---|---|
| <input type="checkbox"/> Individual refused to sign | <input type="checkbox"/> Communications barriers prohibited obtaining the acknowledgement |
| <input type="checkbox"/> Other – Please specify below | <input type="checkbox"/> An emergency situation prevented us from obtaining acknowledgement |