Patient Medical History

Patient's Name _____ **Date of Birth**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health _____	☐	☐
2. Have there been any changes in your general health within the past year _____	☐	☐
3. Date of your last physical exam _____		
4. Physician's name _____		
Address _____		
Phone no. _____		
5. Are you now under the care of a physician _____	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness _____	☐	☐
Please explain _____		
7. Are you taking any medicine(s), including non-prescription medicine? _____	☐	☐
If yes, what medicine(s) are you taking _____		
_____		
8. Have you had any abnormal bleeding _____	☐	☐
9. Do you bruise easily _____	☐	☐
10. Have you ever required a blood transfusion _____	☐	☐
11. Have you had a recent weight loss _____	☐	☐
12. Have you ever taken Fen-Phen or Redux _____	☐	☐
13. Do you use tobacco _____	☐	☐
14. Do you or have you used controlled substances _____	☐	☐
15. Are you wearing contact lenses _____	☐	☐
16. Do you have any disease, condition, or problem not listed above that you think I should know about ___	☐	☐
Women only:		
Are you pregnant or think you may be pregnant _____	☐	☐
Are you nursing _____	☐	☐
Are you taking birth control pills _____	☐	☐

	YES	NO
Are you allergic to or have you had reactions to:		
Local anesthetics like Novocaine _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Sulfa drugs _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Aspirin _____	☐	☐
Iodine _____	☐	☐
Any metals (e.g., nickel, mercury, etc.) _____	☐	☐
Latex/rubber _____	☐	☐
Other (please list) _____		
Do you have, or have you ever had, any of the following:		
Rheumatic heart disease or rheumatic fever _____	☐	☐
Scarlet fever _____	☐	☐
Heart defect or heart murmur _____	☐	☐
Heart trouble, heart attack, or angina _____	☐	☐
Chest pain _____	☐	☐
Shortness of breath _____	☐	☐
Pacemaker _____	☐	☐
Heart surgery _____	☐	☐
High/low blood pressure _____	☐	☐
Congenital heart problem _____	☐	☐
Swelling of feet, ankles, hands _____	☐	☐
Hepatitis, jaundice, or liver disease _____	☐	☐
Stroke _____	☐	☐
Sinus trouble _____	☐	☐
Lung or breathing problems _____	☐	☐
Asthma or hay fever _____	☐	☐
Hives or skin rash _____	☐	☐
Fainting or dizzy spells _____	☐	☐
Diabetes _____	☐	☐
AIDS or HIV infection _____	☐	☐
Thyroid problem _____	☐	☐
Allergies _____	☐	☐
Arthritis or rheumatism _____	☐	☐
Joint replacement or implant _____	☐	☐
Stomach ulcer _____	☐	☐
Kidney trouble _____	☐	☐
Tuberculosis _____	☐	☐
Persistent cough _____	☐	☐
Cough that produces blood _____	☐	☐
Chemotherapy (cancer, leukemia) _____	☐	☐
Sexually transmitted disease _____	☐	☐
Epilepsy or seizures _____	☐	☐
Anemia _____	☐	☐
Glaucoma _____	☐	☐
Nervousness _____	☐	☐
Tonsillitis _____	☐	☐
Tumors _____	☐	☐
Mental health care _____	☐	☐
Back problems _____	☐	☐
Chemical dependency _____	☐	☐
Mitral valve prolapse _____	☐	☐
Cortisone treatment _____	☐	☐
Cold sores/fever blisters _____	☐	☐
Hypoglycemia _____	☐	☐
Eating disorders _____	☐	☐

Patient Medical History

Patient's Name _____ **Date of Birth**_____

Reason for this visit_____

When was your last dental visit_____ What was done then:_____

How often did you visit the dentist before then: _____

Previous dentist (name and location) _____

Have you had a complete series of dental exams (x-rays) taken? When and where: _____

How often do you brush your teeth _____ How often do you floss your teeth:_____

Is your drinking water fluoridated _____

	YES	NO
Do your gums bleed while brushing or flossing_____	☐	☐
Are your teeth sensitive to hot or cold liquids/foods _____	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods_____	☐	☐
Do you feel pain to any of your teeth _____	☐	☐
Do you have any sores or lumps in or near your mouth ____	☐	☐
Have you had any head, neck, or jaw injuries_____	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking _____	☐	☐
Pain (joint, ear, side of face) _____	☐	☐
Difficulty in opening or closing_____	☐	☐
Difficulty in chewing_____	☐	☐
Do you have frequent headaches _____	☐	☐
Do you clench or grind your teeth _____	☐	☐
Do you bite your lips or cheeks frequently _____	☐	☐

	YES	NO
Have you noticed any loosening of your teeth _____	☐	☐
Does food tend to become caught between your teeth_____	☐	☐
Have you ever had periodontal treatment (gums)_____	☐	☐
Ever worn a bite plate or other appliance _____	☐	☐
Have you ever had any difficult extractions in the past_____	☐	☐
Have you ever had any prolonged bleeding following extractions _____	☐	☐
Do you wear dentures or partials _____	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums_____	☐	☐
Have you had ortho/braces in the past _____	☐	☐
Would you be interested in teeth whitening_____	☐	☐
Have you had an unfavorable dental experience _____	☐	☐

If you could change <u>anything</u> about your smile, what would you change? _____

_____

_____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

_____Date_____

Signature of patient or parent if minor

Doctor's Comments_____

_____

_____**Signature**_____**Date**_____

_____

Patient Number

Patient Information (Confidential)

Name_____ Date_____
First Middle Last

Address _____ City_____State_____Zip_____
Cell # _____ Soc. security #_____Birth Date _____ Home phone_____
Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

If college student, F.T./ P.T., name of school _____ City _____State_____
Patient's or parent's employer: _____ Work phone_____
Business address _____ City_____State_____Zip_____
Spouse or parent's name_____ Employer _____ Work phone_____
Whom may we thank for referring you _____
Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient_____
Address _____Home Phone_____
Driver's license #_____ Birth date _____Soc. security #_____
Employer _____ Work phone_____
Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient_____
Birth date_____ Soc. security #_____Date employed: _____
Name of employer _____Union or local #_____Work phone_____
Employer address _____ City_ _____State _____Zip_____
Insurance co.: _____ Tel. _____Grp. #_____Policy/I.D. #_____
Ins. co. address_____ City_____State_____Zip_____
How much is your deductible _____How much have you used _____Max annual benefit_____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient_____
Birth date_____ Soc. security #_____Date employed_____
Name of employer_____ Union or local #_____Work phone_____
Employer address _____ City_____State_____Zip_____
Insurance co._____ Tel. #_____Grp. #_____Policy/I.D. #_____
Ins. co. address_____ City_____State_____Zip_____
How much is your deductible _____ How much have you used_____Max annual benefit_____

X_____ _____

Signature of patient or parent if minor **Patient number**

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

In order to better serve our patients, at times, you may be recorded for training purposes.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Our Financial Policy

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements are part of successful, predictable treatment results. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patients' financial capabilities. Please **read**, **sign**, and **return** the following:

Payment

Payment in full is due at the time of service unless prior arrangements are made. We offer several payment options:

1. We accept **Cash**, **Checks**, **Discover**, **Visa**, **MasterCard** and **American Express**.
2. We offer **pre-payment discounts.**
3. We offer **monthly payment plans** in accordance with the office credit guidelines and **Care Credit.**

Insurance

Our office is committed to helping our patients maximize their benefits. As you may be aware, medical and dental insurance is becoming extremely complex. We are always available to answer your questions, however, your insurance policy is a contract between you and your insurance company and a as a medical provider, we are not party to that agreement.

PPO/Indemnity Policies

Your patient portion must be paid at the time of service. We ask our patients to provide us with complete dental insurance information. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment in full. After 60 days you are responsible for the entire balance and it will be due in full. The quality of insurance policies vary, therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.

Minors

Payment for services for the treatment of minors can be made by cash, check or credit card and is the **responsibility of the adult accompanying that minor**. Also note that minors under the age of 18 are required to be accompanied by an adult.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved specifically for you. **We reserve the right to charge a fee** for all cancelled or missed appointments without a **48 hour notice**.

Service Charges

The policy of this office is to charge a 1% **monthly** (12% annual percentage rate) or a billing charge which will be applied to all **accounts** over **90 days past due**. We will charge $25.00 for returned checks.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement.

_____ _____

Signature of Patient/Responsible Party Date

In order to serve you better, please let us know which days/times work best for you in the event that we have available earlier openings in your Doctor's schedule:

Day(s): _____, _____, _____ Time(s): _____, _____, _____

Insurance Signature on File Authorization

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

_____ _____

Signature of Patient/Responsible Party Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to Signature Smiles Dental Care, Ltd.

_____ _____

Signature of Employee/Subscriber Date

Model Release Form

Congratulations for choosing Signature Smiles Dental Care! We are a family and cosmetic oriented dental practice focusing on enhancing and maintaining our patients' smiles.

I hereby allow Signature Smiles Dental to use my photographs for promotion and/or advertising.

_____ _____

Signature of Patient/Responsible Party Date

I decline the use of my photographs to be used by Signature Smiles Dental Care.

_____ _____

Signature of Patient/Responsible Party Date