SMILES DENTAL SPA
PATIENT INFORMATION

We are pleased to welcome you to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. If you have any questions, don't hesitate to ask.

Name: _____ _____ _____ _____ Gender: ☐ M ☐ F
Last Name First Name MI Preferred Name

Date of birth:_____ SS #: _____ Driver's license #: _____ Married: ☐ Y ☐ N

Home address:_____ City: _____ State:_____ Zip:_____

Home phone:_____ Cell:_____ E-mail: _____

Employer:_____ Spouse's name:_____ Emergency phone # _____

Primary insurance:_____ Group Name: _____ Group # : _____

Subscriber's name: _____ SS #: _____ Subscriber ID #: _____

Secondary insurance:_____ Group Name: _____ Group # : _____

Subscriber's name: _____ SS #: _____ Subscriber ID #: _____

Found us through:_____

(If you were referred by an existing patient, please let us know who so that we can thank them. If you found us online, please let us know where, e.g. Google, yelp, Face book. If you got our brochure in the mail, please mention that.)

OFFICE POLICIES

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment : Cash, Visa, MasterCard, American Express, Discover & Care credit financing. Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $25 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $25 or deposit to reserve the appointment time again, may be required.

Authorizations: I have read the above and agree to the financial and scheduling terms. The information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.
I authorize the release of information necessary to process my dental benefit claims and authorize payment directly to this doctor otherwise payable to me.
I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

Patient Signature: **Date:**

Patient Name : _____

DENTAL HEALTH HISTORY

Previous Dentist: _____ Date of last dental visit: _____

Reason for changing?_____ Reason for today's visit? _____

How often do you brush ?_____ How often do you floss ? _____

	Yes	No
Are you nervous about seeing a dentist?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you avoid brushing any part of your mouth due to pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you noticed any sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you take fluoride supplements?	☐	☐

	Yes	No
Do you clench or grind your jaws frequently?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a facial or jaw injury?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

MEDICAL HEALTH HISTORY

Physicians Name: _____ Phone No. _____ Address: _____

Do you have, or have you had, any of the following?	Yes	No
Heart Problems	☐	☐
Heart murmur / Heart valve problem	☐	☐
Stroke	☐	☐
Cancer/Tumor	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Asthma	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Kidney or bladder problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Pre-medications required by physician	☐	☐

Are you allergic to any of the following?	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pill	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals, latex or rubber dam	☐	☐
Other		

Do you have any disease, condition, or problem not listed previously that you feel we should know about? _

If so, please describe: _____

Do you have, or have you had, any of the following?	Yes	No
Diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		

Have you taken any of the following in the last 12 mo?	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other medications		

Women	Yes	No
Are you taking birth control medication?	☐	☐
Are you pregnant or Nursing?	☐	☐

Patient Signature: Date: Doctor Initials: