# SMILE DESIGN DENTISTRY

| PATIENT INFORMATION | | |
|---|---|---|
| **Patient Name** Last Name First Name | ☐ Male ☐ Female | **Email** |
| **Date of Birth** | **Contact Phone #** | |

Prior Express Consent for Calls/Texts/Email : By providing the number of contact phone number or other wireless device and my email address now or in the future, I expressly consent and agree that you and any of its affiliates, agents, service providers or asssignees may call me using an automatic telephone dialing system or otherwise, leave ma a voice prerecorded, or artificial voice message, or send me a text, email, r other electronic message for any purpose related to the servicing or collection of any account that I may establish with you, or for other informational purposes related to my account or treatment(“Communication”). I also agree that you will not charge for a communication, but my service provider may. I agree that you may monitor and record any telephone calls to assure the quality of its service or for other reasons.

___________ initial

| Home Address | City | Zip | |
|---|---|---|---|
| Emergency Contact | Name | Phone # | Relationship |

| PRIMARY DENTAL INSURANCE | SECONCARY DENTAL INSURANCE |
|---|---|
| Is subscriber the same as patient? ☐ Yes ☐ No | Is subscriber the same as patient? ☐ Yes ☐ No |
| Name of Subscriber: ______________________________ | Name of Subscriber: ______________________________ |
| Subscriber SSN : _________________________________ | Subscriber SSN : _________________________________ |
| Subscriber Date of Birth : _________________________ | Subscriber Date of Birth : _________________________ |
| Insurance Company : _____________________________ | Insurance Company : _____________________________ |
| Insurance ID : ___________________________________ | Insurance ID : ___________________________________ |
| Group # : ______________________________________ | Group # : ______________________________________ |
| Patient relationship to subscriber : _________________ | Patient relationship to subscriber : _________________ |

| RESPONSIBLE PARTY (Disregard if same as above) | | | |
|---|---|---|---|
| Last Name First Name | | Date of Birth | Relationship to patient |
| SSN# | Driver License # | Contact phone # | |
| Address | | City | Zip |
| Employer | | Employer Contact # | |

**REASON FOR VISIT**

☐ Check Up & Prophy ☐ Pain ☐ Sensitivity

☐ Broken Tooth/Crown ☐ Denture ☐ Implant

☐ Bleeding Gum ☐ Difficulty in Chewing ☐ Cosmetic

☐ Others : ________________________________________________________________________

## DENTAL HISTORY

Date of last dental visit :

- [ ] I do not know exact date
- [ ] Less than 6 month
- [ ] 6month – 1 year
- [ ] More than 1 year
- [ ] Never

Please check any conditions that apply to you :

- [ ] Pain
- [ ] Sensitive Teeth
- [ ] Swollen/Bleeding Gum
- [ ] Broken/Loosen Teeth
- [ ] Teeth Grinding/Clenching
- [ ] Other : ______________________________

## MEDICAL HISTORY

Check any conditions that apply to you:

- [ ] None
- [ ] Alcoholism
- [ ] Allergies or Hives
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Stroke
- [ ] Cancer
- [ ] Chronic Sinus Problem
- [ ] Diabetes
- [ ] Dementia
- [ ] Drug Addiction
- [ ] Excessive Bleeding
- [ ] Heart problem
- [ ] Explain : ______________________
- [ ] Hepatitis Type : _____________
- [ ] High Blood Pressure
- [ ] Blood Thinner
- [ ] Joint Problem
- [ ] Kidney Problem
- [ ] Lung disease
- [ ] Lupus
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Seizure
- [ ] Stomach Problem
- [ ] Low Blood Pressure
- [ ] HIV
- [ ] Chemotherapy
- [ ] Liver Problem
- [ ] Other : ____________________________________________________________________________________

## MEDICATION

Are you taking any prescription medications? [ ] Yes [ ] No

If yes, please list all the medication and dose taken : ______________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Do you or have any used bisphosphonate medication? [ ] Yes [ ] No

(Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)

If Yes, please provide us the name of medication and the time you started to take the medication :

_____________________________________________________________________________________________________

## ALLERGIES

Please check if you have any drug allergies:

- [ ] Penicillin
- [ ] Sulfa Drugs
- [ ] Iodine
- [ ] Amoxicillin
- [ ] Dental Anesthetic
- [ ] Aspirin
- [ ] Other Antibiotics : _______________
- [ ] Codeine/Narcotic
- [ ] Other : ____________________________________________________________________________________

Are you allergic or have you had an adverse reaction to any?

- [ ] Latex
- [ ] Metals/Nickels/Jewelry
- [ ] Other : ____________________________________________________________________________________

| SOCIAL | WOMEN PATIENT ONLY |
| --- | --- |
| Do you use tobacco? ☐ Yes ☐ No<br>If yes, how long? ___________ How often? __________<br>Do you use alcohol? ☐ Yes ☐ No<br>Do you have any medical conditions not listed above? If yes, please list : ________________________________ | Are you currently pregnant? ☐ Yes ☐ No<br>Are you nursing? ☐ Yes ☐ No<br>Are you taking any birth control prescription?<br>☐ Yes ☐ No<br>*** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control. |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

_______________________________________________________________ _______________

Name of Patient Patient’s Sign/Parent or Guardian if patient is minor Date

## CONSENT FOR SERVICES

As a condition of treatment by this office, **all financial arrangements must be made in advance.** The practice depends upon collection from patients for the cost incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.

Any treatment recommendations are made based on what is best for you, our patients; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. **It is our office policy to collect patient's estimated portion at the time of service.**

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. An annual percentage rate of 18 % will be applied monthly to any balance not paid within 60 days, unless written financial arrangements have been established.
I have read and understand the above conditions of treatment and payment; I agree and give my consent for treatment.

Signature ____________________________________________________ Date ________________________

## MISSED APPOINTMENT/SHORT NOTICE CANCELLATIONS

Without 48 hours advance notice, there will be a fee of $50 for any missed appointment. The missed appointment fee must be paid prior to future office visit. Initial ______________________

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY :**
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2012, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. You may contact us to request more information about our privacy practices.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification, licensing or credentialing activities.

Signature ____________________________________________________ Date ________________________

## HIPPA COMPLIANCE

In compliance with the Federal HIPPA policy we are requesting your permission to send out appointment reminders via email or test on file. These messages will have your name, time and date of the appointment.
I give SMILE DESIGN DENTISTRY a permission to send out information reminders via email or text.

Signature ____________________________________________________ Date ________________________