Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ (NO. YEARS EMPLOYED)

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin, Local Anesthetic, Erythromycin, Latex (balloons, gloves, etc.), Nitrous Oxide, Codeine, Penicillin

Are you aware of being allergic to any other medications or substances?

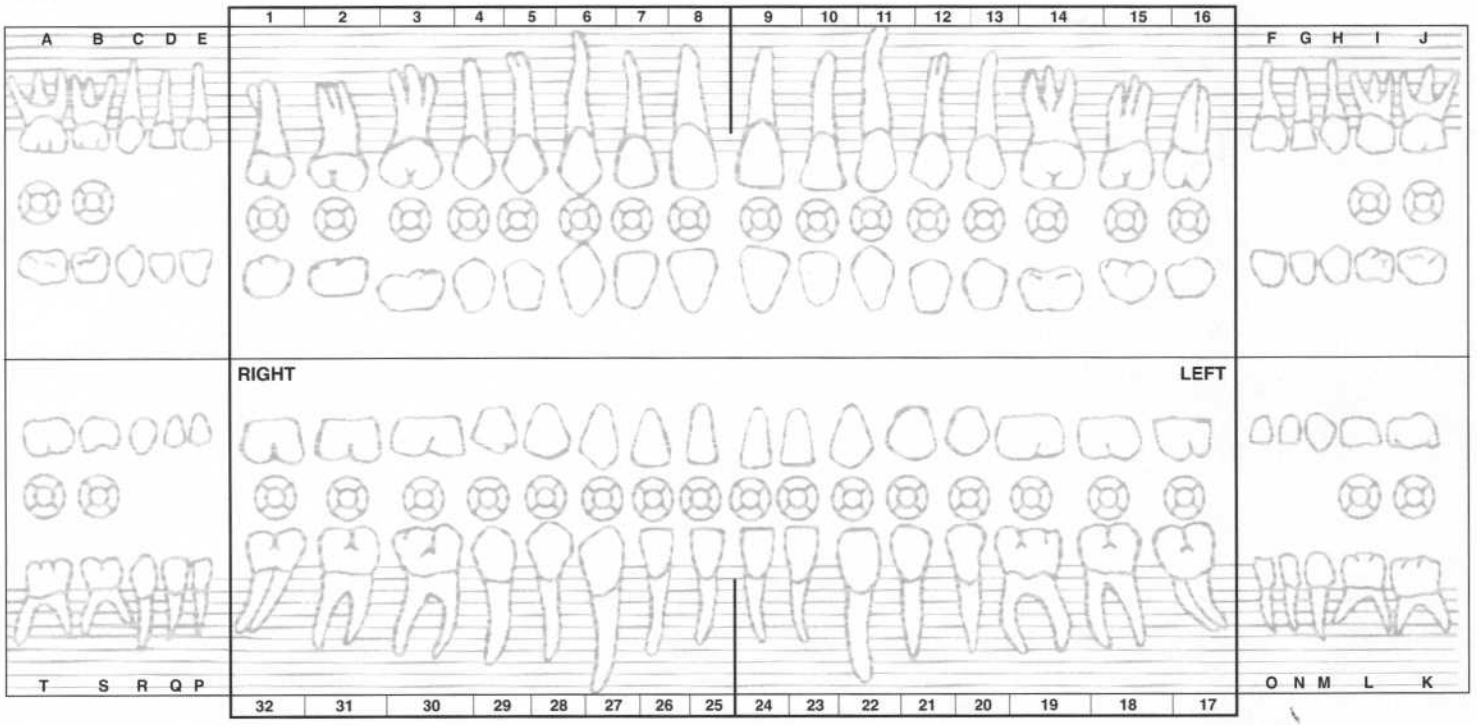
If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

COMPLETED TREATMENT



INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:	☐ Slight	☐ Moderate	☐ Severe
SOFT PLAQUE BUILDUP:	☐ Slight	☐ Moderate	☐ Heavy
HARD CALCULUS BUILDUP:	☐ Light	☐ Moderate	☐ Heavy
STAINS:	☐ Light	☐ Moderate	☐ Heavy
HOME CARE EFFECTIVENESS:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL CONDITION:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL DIAGNOSIS:	☐ Normal	☐ Gingivitis	
PERIODONTITIS:	☐ Early	☐ Moderate	☐ Advanced

MUCOGINGIVAL DEFECTS #s: _____

CLINICAL DATA:

OCCLUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: _____

T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

INITIAL SOFT TISSUE EXAM:

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER _____

☐ NO BONE LOSS

☐ SLIGHT BONE LOSS (04600)

☐ MODERATE BONE LOSS (04700)

☐ MAJOR BONE LOSS (04800)

☐ BEGINNING FURCATION (04700)

☐ ADVANCED FURCATION (04800)

☐ OTHER: _____

QUADRANTS

UR	UL	LR	LL

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE

MONTH DAY YEAR

EXISTING PROSTHESIS:

MAX: _____ DATE PLACED: _____ CONDITION: _____

MAND: _____ DATE PLACED: _____ CONDITION: _____

REFERRALS:

PERIO: _____ ORTHO: _____ ENDO: _____

ORAL SURG: _____ MD: _____ OTHER: _____

NOTES

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.
I give permission for my account and treatment to be discussed with the following person(s):

_____

_____

Please print your name here

_____

Signature *Date*

Appointment Policy:

Every effort is made to keep on schedule so we ask patients to be prompt and to keep their appointments. Our standard office policy regarding appointments is as follows:

We will confirm your appointment ahead of time, but please do not depend on this as it is just a courtesy. Your appointment card also serves as a reminder of your appointment. That time has been reserved especially for you. All appointments must be confirmed!

If you need to change your appointment, we require **AT LEAST 48 HOURS NOTICE**, prior to the appointment time, to avoid a $50 charge for our lost time. Exceptions to this rule can be determined only on an individual basis according to circumstances. **Work is not an extenuating circumstance** as you should let your employer know ahead of time that you are unavailable for work at your appointment time. Thank you for your cooperation.

Patient/Guardian Signature:_____ Date:_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

__The patient refused to sign.
__Due to an emergency situation it was not possible to obtain an acknowledgement.
__We weren't able to communicate with the patient.
__Other *(Please provide specific details)*

_____

_____

_____

Employee signature *Date*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

Patient Liability Agreement

I understand that I am financially responsible for all bills incurred while under the care of The Smile Center. In the event that my account is not paid in full, I shall be liable for any and all costs of collection, including, but not limited to a 35% fee* of the outstanding balance if my account is forwarded to a collection agency for collection; and, if my account is forwarded to an attorney for legal proceedings I agree to be liable for an additional attorney fee making a total collection and attorney fee of 50% of the outstanding balance.

I further understand that there shall be 1.5% interest charged per month on any outstanding balance.

By signing below, I hereby indicate that: 1) I have read this contract, 2) I understand the terms of this contract and 3) I agree to the terms of this contract.

Please initial:

_____ I agree to pay a 35% collection fee* on the outstanding balance if my account is forwarded to a collection agency.

_____I agree to pay a 50% combined collection and attorney fee if my account is forwarded to an attorney for legal proceedings.

_____I agree to pay 1.5% interest per month on any outstanding balance.

*(as defined by the balance of the bill due divided by .65)

_____

Patient/Guardian (Print Clearly)

_____ Date: _____

Patient/Guardian (Signature)

Pre-Authorized Dental Health Care Payment Form

I, _____, authorize the Smile Center to keep my signature on file and charge my credit card account for:
*Charges for appointments attended (fees for services rendered)
*Charges for missed appointments (including those canceled within 2 business days)
*Balances for charges not paid within 90 days
I understand that I may revoke this agreement with 30 days' notice by a written request.

Patient Name: _____

Cardholder name:_____

Cardholder billing address:_____

_____

_____

□ Visa □ Care Credit
□ MasterCard □ Discover
Account number: _____

Expiration Date:_____CVV Code (3 digit #):_____

Signature: _____ Date: _____

The Smile Center agrees to charge only for reasons stated above.