



Name _____ Date _____

How did you find out about our office? _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

Social Security # _____ Date of Birth _____ Age _____

Marital Status Single Married Separated Divorced Widowed

Occupation _____ Employer Name _____

Business Address _____ City _____ Zip _____

Person to Contact in an Emergency _____ Relationship _____

Phone Number(s) _____

Party Responsible for Payment of Account _____ Relationship _____

Phone Number(s) _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

Name of Insurance Co. _____

Group # _____ Member Id # _____

Insurance Co. Address _____

Phone _____

Are you the policy holder? YES NO If NO, please answer the following:

Policy Holders Name: _____ Policy Holder's Date of Birth _____

Occupation _____ Employer Name _____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out areas which pertain to you.

- ALL INFORMATION IS PRIVATE AND CONFIDENTIAL -

DENTAL HISTORY

Date of Last Visit _____ Date of Last Cleaning _____ Last F.M. X-Rays _____

Check any of the following you have had/currently have:

- | | | |
|--|---|-----------------------------|
| <input type="checkbox"/> Mouth Discomfort | <input type="checkbox"/> Awake with Sore Jaw | Reason for this Visit _____ |
| <input type="checkbox"/> Previous Periodontal Treatment | <input type="checkbox"/> Mouth Odor or Bad Taste | _____ |
| <input type="checkbox"/> Trenchmouth or Pyorrhea | <input type="checkbox"/> Cold Sores or Fever Blisters | _____ |
| <input type="checkbox"/> Gum Abscesses | <input type="checkbox"/> Other Oral Lesions | _____ |
| <input type="checkbox"/> Gums Bleed When Brushing | <input type="checkbox"/> Fear of Dental Treatment | _____ |
| <input type="checkbox"/> Loose or Shifting Teeth | <input type="checkbox"/> Bad Dental Experience | _____ |
| <input type="checkbox"/> Trouble in Chewing or Speaking | <input type="checkbox"/> Had Immediate Relatives Lose | _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> All of Their Natural Teeth | _____ |
| <input type="checkbox"/> Grind or Clinch Your Teeth | | _____ |
| <input type="checkbox"/> Clicking, Popping or Pain in Jaw | <input type="checkbox"/> Complications with or | _____ |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Following Previous Dental | _____ |
| <input type="checkbox"/> Sensitive Teeth (Heat, Cold, or Sweets) | <input type="checkbox"/> or Oral Surgical Treatment | _____ |



PATIENT NAME _____

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 you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No N/A _____
- Have you ever been hospitalized or had a major operation? Yes No N/A _____
- Have you ever had a serious head or neck injury? Yes No N/A _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No N/A _____
- Are you on a special diet? Yes No N/A _____
- Do you use tobacco? Yes No N/A _____
- Do you use controlled substances? Yes No N/A _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Other _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness or injury not listed above? Yes No N/A

Medications: _____

* Condition may require medication N/A- Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

 SIGNATURE OF PATIENT, PARENT, or GUARDIAN

 DATE



I. Financial Policy

At all of your visits you will be responsible for the estimated amount insurance will not cover plus any deductible. When the actual benefits are received from the insurance company, your account will be adjusted accordingly. Each plan is different, but in general, insurance usually covers about 70% of simple care and 50% of major work. Please be aware that you will be ultimately responsible for payment of dental services regardless of the amount the insurance company pays.

Because we understand the value of insurance benefits to our patients, we will be happy to complete and file your insurance forms at no charge. However, we do not file secondary insurances. We will print out the forms you will need if you have two insurance policies and explain what you should do from there. We always try our best to work with your insurance company to maximize the benefits you receive from your plan. If you have any questions about your account, please ask for assistance from our friendly front office staff. We accept, cash, check, money orders, Visa, MasterCard, Discover, American Express and Care Credit for payment. You can also view and pay your balance at www.smiledash.com.

I _____ understand that I am responsible for all fees regardless of insurance coverage. I also understand that as treatment progresses the above fees may have to be adjusted. In the event that my insurance does not fully cover my estimated portion, I will be responsible for the remaining balance. If insurance overpays, leaving a balance of less than \$100, the credit will be held on the account for future services or products. Any account with a balance 30 days past due will be subject to a finance charge of 0.83% (minimum of \$1.00). In the event that my payments are not received within 90 days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.

II. Cancellation Notice

If you must re-schedule your appointment, we require 24 hours notice or there will be a fee of \$35 per hour of scheduled time charged to your account. (Please note, any Monday appointments need to be addressed no later than Friday.)

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

I hereby consent to the procedures and protocol of this office.

Signature of patient or parent/guardian if minor

date

III. Notice of Privacy Practices

Notice of Privacy Practices is attached to these forms and/or a laminated copy is available at the front desk. If you would like to receive a paper copy for your personal records, please ask one of our front office team members, and they will be happy to assist you.

Acknowledgement of Notice of Privacy Practices

Print Name

Signature

date



Consent Form for Dental Treatment

The dentist has fully explained to me the purpose of the procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes) including but not limited to bleeding, infection, numbness, swelling, tooth damage, root canal therapy, and nerve exposure requiring referral to a dental specialist, attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).

Print Name

Signature

date