Smile & Shine DENTAL

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Please present photo ID to receptionist upon arrival.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Wireless Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Preferred Contact Method: ☐ WirelessPh ☐ WorkPhon ☐ HomePhone ☐ Email

Preferred Contact Method for Confirmations ☐ WirelessPh ☐ WorkPhone ☐ HomePhone ☐ Email

Student status (if dependent over 19, for insurance): ☐ Nonstudent ☐ Fulltime ☐ Parttime

How did you hear about us? (Please specify: Google, Facebook Ad, Family/Friend referral, etc.)

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

NO INSURANCE ☐

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Subscriber Birthday: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Subscriber Birthday: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

Smile & Shine DENTAL

Please fill out this form in its entirety. We cannot accept form with any missing information. Type N/A if it does not apply to you.

Last Name: _____ First Name: _____ Birthdate: _____

Name of Primary Care Provider: _____ Phone #: _____

Emergency Contact: _____ Phone # _____

Reason for today's visit: _____ Are you in pain? _____

Dental History

New patients:

Name of former dentist: _____ Phone #: _____

Date of last cleaning and exam: _____

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Check if you have any of the following problems? ☐ NONE

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection
- ☐ Grinding or clenching teeth
- ☐ Loose or broken teeth
- ☐ Periodontal treatments
- ☐ Sore or growth in your mouth
- ☐ Sensitivity when biting
- ☐ Sensitivity to hot
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets

Medical History

Check if you have any of the following medical conditions? ☐ NONE

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Artificial Heart Valve
- ☐ Arthritis
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Blood Problems
- ☐ Cancer _____
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Dementia
- ☐ Diabetes (Type I)
- ☐ Diabetes (Type II)
  Last A1C:_____
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
  CD4 count:_____
- ☐ Joint Replacement
  Type:_____
  Date:_____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mobility Impairment
- ☐ Pacemaker _____
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sinus Trouble
- ☐ Stroke _____
- ☐ Thyroid Prolems
- ☐ Tuberculosis(TB)
- ☐ Ulcers
- ☐ Visual Impairment

Other: _____

For Women:

- ☐ Pregnancy
- ☐ Nursing
- ☐ Taking Birth Control Pills

Are you currently taking or have ever taken Oral or IV Biosphosphonates? ☐Yes ☐ No

If yes, please explain when and how long: _____

Have you had any serious illness or operations? ☐Yes ☐No

If yes, please explain and provide approximate dates: _____

Do you require antibiotics prior to dental procedures? ☐Yes ☐ No

Do you use any tobacco products? ☐Yes ☐No
(Such as: smoking cigarettes, chewing tobacco, vaping)

If yes, please explain what kind, how much, and how often: _____

Any unusual reactions to dental injections? ☐ Yes ☐ No

If yes, please explain. _____

Please provide your perferred pharmacy.

Pharmacy Name: _____ Phone Number: _____

Please list all medications, supplements or vitamins you are taking: ☐ NONE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies(any other allergies not listed here add to the other space): ☐ NONE

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Epinephrine
- ☐ Amoxicillin
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Novocaine

Other: _____

Patient or Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Notice of Privacy Policies

Last Name: First Name: Birthdate:

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. Please make this request in writing to our office.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations

- The practice reserves the right to change the privacy policy as allowed by law

- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions

- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

- The practice may condition receipt of treatment upon execution of this consent

You ascertain that by your signature you have reviewed our notice before signing this consent.

May we phone or email you to confirm appointments? Yes or No _____

May we leave a message on your answering machine at home or on your cell phone? Yes or No _____

If a referral is needed, may we share your information with the treating Specialist we refer to? Yes or No _____

Who may we dicuss your dental conditions with? Name and Relationship: _____

Phone Number: _____

Patient/Parent or Guardian Signature: _____ Date:_____

Financial Agreement

Last Name: First Name: Birthdate:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

* Payment for treatment completed will be paid within 30days of date of service to avoid being sent to collections.

* If sent to collections, I agree to pay all related fees and court costs.

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

* I will pay a fee of $75 for appointments broken without 24 hours notice.

* Treatment plans may change, and I will be responsible for the work actually done.

Patient/Parent or Guardian Signature:_____ Date:_____