ALL SMILES
DENTISTRY

Patient Information:

Date _____

Patient's Name _____ Sex: M☐ F☐ Date of Birth _____ Age _____

Marital Status _____ Spouse/Parent Name _____

Address _____ City/State/Zip _____

Home Phone _____

Cell Phone _____ Would you like to receive text reminders? Y☐ N☐

Email address _____ Would you like to receive email reminders? Y☐ N☐

Employer _____ Work Phone _____

Social Security Number _____ (Please note that SSN is used in identification by many insurance companies and helps us in processing your claims.)

Insurance Information:

Policy Holder's Name _____ SSN _____

DOB _____ Employer _____

Name of Insurance Company _____ Phone _____

Additional insurance coverage _____

Responsible party's name and address if different than patient/insured:

_____

How were you referred to our office? _____

To help us provide the best dental care possible to you, please answer the following:

Date of last dental visit _____ How often do you get your teeth cleaned? _____

What was done at your last dental appointment? _____

Does your jaw ever ache, pop, click, or do you clench or grind your teeth? Y☐ N☐

When was your last full mouth x-ray series (16 x-rays) or Panorex? _____

Have you ever been told to take antibiotics prior to dental visits? Y☐ N☐

If yes, what has been prescribed? _____

What pharmacy do you use? _____ Phone _____

Are you apprehensive about dental care? Y☐ N☐

Have you ever reacted unfavorably to previous medical/dental treatment, anesthetics (shots), or medications? Y☐ N☐

If so, please explain: _____

_____

Would you like to improve your smile? Y☐ N☐ If so, how and what have you tried to this point?

_____

Would you like to know more about (circle) Braces☐ Invisalign☐ Whitening☐ Veneers (laminates)☐ Implants?☐

**Please arrive 10 minutes prior to your first dental visit. We appreciate you becoming our patient and look forward to seeing you soon!

Current Dental Information

How were you referred to our office? _____
Are you currently experiencing a dental problem? Y/N
What area of your mouth is it in?

_____

Are you sensitive to cold? Y/N Hot? Y/N Biting? Y/N
Pressure pain? Y/N
How long has it been going on?_____
Explain:

_____

_____

Past and Future Dental Information

Date of last dental visit _____ How often do you have your teen cleaned? _____

Date of last full mouth x-rays or Panorex Xray?

_____

Tell us about any past experience with Dental offices that might help us with your care.

_____

_____

How do you feel about your teeth now? In the past?

_____

_____

Is there anything you would like to change about your teeth?

_____

_____

How do you feel about your smile?

_____

_____

Are you interested in OPTIMAL dental health/looks?

_____

_____

Do you have any friends or family we could help?

_____

_____

Office Use Only

Patient Name: Birth Date: Date Created:

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	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

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	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes	
Do you use controlled substances?	○ Yes ○ No	If yes	

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

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:

X Date:_____

Financial Policy

Thank you for choosing All Smiles Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available.

An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Payment Options:

1) Payment is required at time of service. If Insurance the estimated portion is required

2) If you cannot pay at your visit with the below agreement the estimated portion will be assessed on your credit card after 30 days.

3) Care Credit - Monthly payment plan with no interest if paid within the periods. Brochure Available. Wwwcarecredit.com.

Credit Card Type: (circle one)

Visa MasterCard American Express Discover Card

Card Number: _____ _____ _____ _____

Expiration: _____ CVC _____

I hereby authorize my credit/debit card to be charged for the amount displayed above on the intervals agreed upon, until the balance is paid in full.

SIGNATURE _____ DATE _____

No Show/Late/Cancellation Policy:

With each appointment, time has been set aside specifically for you. If you find you are unable to keep this appointment, we ask that you notify our office a minimum of 24 hours prior to the appointment. This will make the time available for another patient. There is an answering machine available 24 hours a day, 7 days a week to leave a message regarding your appointment if it is after office hours.

If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule or services may be shortened in order to honor time we have set aside for other patients with scheduled appointments.

If you have not cancelled or rescheduled your appointment 24 hours prior to the appointment, you may be charged a broken appointment fee of $25.00, which is not covered by insurance.

[1]If we do not receive payment from your insurance carrier within 90 days or after two attempts at filing a claim on your behalf, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
[2]Subject to credit approval. See www.carecredit.com for information on terms.

All Smiles Dentistry 10/14

I agree to the terms specified above.

_____ _____

Signature Date

_____

Print Name

all smiles
DENTISTRY

Please review the **HIPAA policy.** We will be happy to provide answers for any of your questions.

I would like the following people to be able to speak with All Smiles Dentistry regarding my care (i.e. name of spouse, parents, siblings, or caregiver):

_____

_____

Acknowledgement of receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have read the **HIPAA Notice of Privacy Practices** for All Smiles Dentistry.

_____ _____

Printed Name Date

_____

Signature of Patient or Personal Representative

Authority of Personal Representative to sign for patient : __Parent __Guardian __Power of Attorney _____Other

Please note: It is your right to refuse to sign this Acknowledgement.