



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

¹If 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.

²Subject 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



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.