Patient Name_____
Last First MI (Preferred)

Birthdate_____ *Under age 18 □ Yes □ No Parent/Guardian _____
SS#_____-_____-_____ Sex □Male □ Female
Address _____
City _____ State _____ Zip _____
Home Phone_____ Cell Phone _____ Email _____@_____

How did you hear about us? _____
Emergency Contact Name: _____Phone Number: _____Relationship: _____

Method of Payment □ Private or Employer Sponsored Insurance □ Medicare/Medicaid □ Self Pay

DENTAL POLICY IDENTIFICATION

Your relationship to Subscriber □ Self □ Spouse □ Child
Subscriber/Policy Holder Name _____ ID # _____
Insurance Company _____ Phone_____
If applicable:
Employer _____ Group Name _____ Group #_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our HIPAA/Privacy Policy is available on our website, via e-mail or hardcopy. For your convenience, a copy is posted in our waiting room.

I, _____ have received/have access to a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

SIGNATURE ON FILE

Must Be Checked

□ I authorize use of this form on all of my insurance submissions.
□ I authorize the release of information to all my Insurance Companies.
□ ***I understand that I am responsible for the bill.***
□ I authorize payment directly to my doctor.
□ I permit a copy of this authorization to be used in place of the original.
□ My signature also applies to my dependents.

Signature: _____ Date: _____

CONSENT

I understand that I am personally responsible for all charges incurred by me, or my dependents in the course of my, our dental treatments. Your Smile agrees to submit to my insurance company for all services and comply with any participating agreements.

Consent

Your Smile will not accept insurance payments from non-participating companies as paid in full. I also understand that I am personally responsible to pay for treatment that is denied or not a covered benefit with my insurance. I may be required to prepay co-payments or balances due to prior to scheduling appointment, particularly on longer or more involved treatments.

Disclaimer:

I understand that it is my responsibility to keep scheduled appointments. Your Smile requires a **48** hours notification for all cancellations. Failure to provide required notice may result in a $50.00 charge. Payment by cash, check or credit card is due at the time of service. There is a $35.00 returned check fee for all returned checks. A monthly fee of $10.00 will be charged on all accounts over 30 days. In the event of non-payment, patient agrees to pay collection costs including court costs, private process server fees and reasonable attorney's fees.

Signature: _____ Date: _____

MEDICAL HISTORY

*Please check all that apply

- ○ AIDS/HIV Positive
- ○ Alzheimer's Disease
- ○ Anemia
- ○ Angina
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Blood Disease
- ○ Blood Transfusion
- ○ Breathing Problems
- ○ Cancer/Tumors
- ○ Chemotherapy
- ○ Chest Pains
- ○ Cortisone Medicine
- ○ Diabetes
- ○ Drug/Alcohol Addiction (Within the past 5 years)
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Fainting or Dizzy Spells
- ○ Glaucoma
- ○ Heart Attack
- ○ Heart Pace Maker
- ○ Heart Trouble or Disease
- ○ Hepatitis A/ B/ C
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Hypoglycemia
- ○ Kidney Problems
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Methadone/Suboxone Prog.
- ○ Pain in Jaw or Joints
- ○ Psychiatric Problems
- ○ Radiation Treatment
- ○ Recreational Drug Use
- ○ Rheumatism
- ○ Spina Bifida
- ○ Stomach/Intestinal Disease
- ○ Stroke
- ○ Thyroid Problems
- ○ Tobacco usage
- ○ Tuberculosis
- ○ Venereal Disease/ S.T.D.'s
- ○ None of the above

Allergies:

- ○ Aspirin
- ○ Penicillin
- ○ Codeine
- ○ Latex
- ○ Local Anesthetics
- ○ Metals
- ○ Foods: _____
- ○ Other:_____
- ○ No Known Allergies

Women

- Are you pregnant: □ yes □ no
- if so, week _____
- Taking oral contraceptives: □ yes □ no
- Nursing: □ yes □ no

Children

- Do you have any of the following habits?
  - ○ Thumb/Finger sucking
  - ○ Clenching or Grinding
  - ○ Tongue Thrust
  - ○ Currently bottle fed -at all
- Is your water fluoridated: □ yes □ no
- Do you still have your wisdom teeth: □ yes □ no

Please list any medications both over the counter and prescription that you are taking: □ Separate list attached □ None

_____

_____

Current Pharmacy: _____

Please use the following space to inform us of any medical problems not listed or that you may need to further make us aware of: □ None

_____

_____

DENTAL HISTORY

Do you have any present dental complaints? □ yes □ no

_____

When was your last Full Mouth Xray (or Panorex) taken? _____ Where? _____

**If taken within 5 years, with the same insurance plan, you may be responsible for Xrays taken at Your Smile.*

When was your last dental cleaning? _____ Where? _____

How many times a week do you floss? _____ Really? □ yes □ no How many times a day do you brush? _____

*Do you like your smile? □ yes □ no What would you change? _____

***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's my responsibility to inform the dental office of any changes in my medical status.**

Signature: _____ **Date:** _____

- This form has been minimized for your convenience.
- If you would like to be seen today, we ask that you fill this form out completely and accurately.
- We promise that our current patients will not have to fill them out every time they come in.
- There are 4 signature portions of this form. Did you find them all?
- **Please bring this paper, along with your identification and insurance card to the front desk when you are done.**
- Smile!