smileworks
REVEALING THE NATURAL BEAUTY OF SMILES

Patient Information

Patient Name: _____ Date: _____

Last First MI

E-mail: _____ ☐ I would like to receive correspondences via email

Whom may we thank for referring you to our practice: _____

If not referred by a patient, please let us know how you heard about us. _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship to patient: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. We also understand the financial limitations that influence your choice of care. We want to assure you of our flexible approach to financing. The practice depends upon reimbursement from the patients costs incurred in their care and financial responsibility on the part of each patient. We will file to most insurance policies as a courtesy, and receive reimbursements from the dental insurance companies with your permission. We always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. Patients who carry dental insurance understand that all dental services furnished are charged on the day the services are rendered. At the time of service, we will ask you for an estimated co-payment and any deductibles that may apply. Insurance plans generally only cover a portion of total treatment costs. It is your responsibility to pay any balance not paid by the insurance company since insurance coverage is between you and your insurance company. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. If your account becomes past due, we will take necessary steps to collect the balance owed. If we have to refer your account to a collection agency, or small claims court, you agree to pay all of the cost/ fees which are incurred. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matter related to this form.

BROKEN APPOINTMENTS – Patient visits are the most integral part of our day. We reserve time and prepare in advance for each patient's arrival. Please understand that when we make an appointment, we are setting aside enough time to do our best work and each appointment is for one patient only. Therefore, a broken appointment without adequate notice results in wasted time for us, adding to the cost of providing care to our patients. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those the best we can. If you are unable to keep your scheduled appointment, we kindly ask you give us 24 hour notice. We will assess a fee of $50 for last minute cancellations, missed appointments and short notice rescheduling. We will consider exceptions on an individual basis. I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of patient, parent or guardian Date Relationship to patient

Privacy Practices Acknowledgement – HIPAA

I understand that Smileworks strictly adheres to the ***Health Insurance Portability & Accountability Act of 1996*** ("HIPPA") including the OMNIBUS Ruling in order to protect my privacy as a patient. As a patient, I understand that my information can be used to conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly. It may also be used to obtain payment from the third party payers or conduct normal healthcare operations such as quality assessments and physician certifications. I understand that if I would like to read a detailed Notice of Privacy Practices, I may request to see one at anytime and one will be furnished.

_____

Signature of patient, parent or guardian Date Relationship to patient

MEDICAL HISTORY

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PATIENT NAME _____ Birth Date _____

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

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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 above? ◯ Yes ◯ No _____

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 _____ DATE _____

Dental History

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Patient Name: _____ Date: _____

What is the reason for your visit today _____
_____

Are any of your teeth sensitive to *hot or cold*?	YES	NO	Have you ever had braces?	YES	NO
Are any of your teeth sensitive to *sweets*?	YES	NO	Have you ever had oral surgery?	YES	NO
Any sensitivity to *biting or chewing pressure*?	YES	NO	Have you ever had periodontal surgery?	YES	NO
Do you notice mouth odors?	YES	NO	Do you wear a bite or "night" guard?	YES	NO
Do you notice bad tastes?	YES	NO	Any serious injury to the mouth or head?	YES	NO
Do your gums bleed or hurt?	YES	NO	Please describe: _____		
If yes, how often? _____			_____		
Does food get caught between your teeth?	YES	NO	Does your jaw click or pop?	YES	NO
Is this a problem you want corrected?	YES	NO	Any pain in your jaw joint?	YES	NO
Do you clench or grind your teeth?	YES	NO	Frequent headaches?	YES	NO
Do you ever notice tired jaws or sore teeth?	YES	NO	Frequency and time of day of headaches: _____		
Do you smoke or chew tobacco?	YES	NO	_____		
Are you currently missing any teeth?	YES	NO	Do you feel nervous about dental treatment?	YES	NO
Is this a problem you want corrected?	YES	NO	If so, what are your concerns? _____		

Date of: Last dental visit? _____ Last cleaning? _____ Last x-rays? _____

What was done at your last dental visit? _____
_____

Previous Dentist's Name: _____ Phone #: _____

Your reason for leaving their office: _____
What did you **like** about your previous dental experiences? _____
_____

What did you **dislike** about your previous dental experiences? _____
_____

How often do you normally have dental examinations? Once per year Twice per year Three times per year More

How often would you prefer dental examinations? Once per year Twice per year Three times per year More

Would you like to discuss your options to enhance your smile? (i.e. whiter, straighter teeth) YES NO

If yes, what are your goals & expectations? _____

Are you concerned about your silver mercury fillings? YES NO

Is there anything else / other dental concerns we have not asked about that you want us to know? _____
_____
_____

How can we make each of your future visits more enjoyable? _____
_____

NOTES: _____

_____