

**WELCOME TO THE OFFICE
OF
RONALD C. SMILEY, D.M.D., P.C.**

Doctor Smiley and his staff are committed to providing patients with the best possible treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our **FINANCIAL POLICY**, which we require you to read and sign prior to any treatment.

**FULL PAYMENT IS DUE AT TIME OF SERVICE. WE DO NOT "BILL,"
WE ACCEPT CASH, CHECKS AND CREDIT CARDS (VISA, MASTERCARD AND DISCOVER)
A payment arrangement with AMERICAN GENERAL is also available.**

I (the patient or guardian) assume financial responsibility for services rendered and agree to pay the costs and expenses incurred to collect amounts owed, including attorneys' fees and court costs. I understand that unpaid charges shall incur interest at a rate of 1.5% Per Month from the date of service and that a service charge of \$35.00 shall be applied each time my check is dishonored.

DENTAL INSURANCE

Your insurance coverage is a contract between you and your insurance company. Responsibility for payment of fees is the obligation of each patient. We will file your insurance claim as a courtesy for you. However any unmet deductible or estimated portion is due at the time of service. If your insurance company has a direct reimbursement policy, you will be required to pay for your services in full at the time they are rendered.

If we do file any claim for services rendered and your insurance company fails to pay within 30 days, you then become totally responsible for payment in full.

MISSED APPOINTMENTS

We require at least 24 hours advance notice if you are unable to keep your appointment. This courtesy allows someone else to be treated, a courtesy you would want if the circumstances were reversed. **If you miss two (2) scheduled appointments without 24 hours advance Notice of cancellation**, it will be your responsibility to pay for your next appointment in full before you are rescheduled. If for any reason you do not keep your appointment or cancel with less than 24 hours notice, your payment will be forfeited.

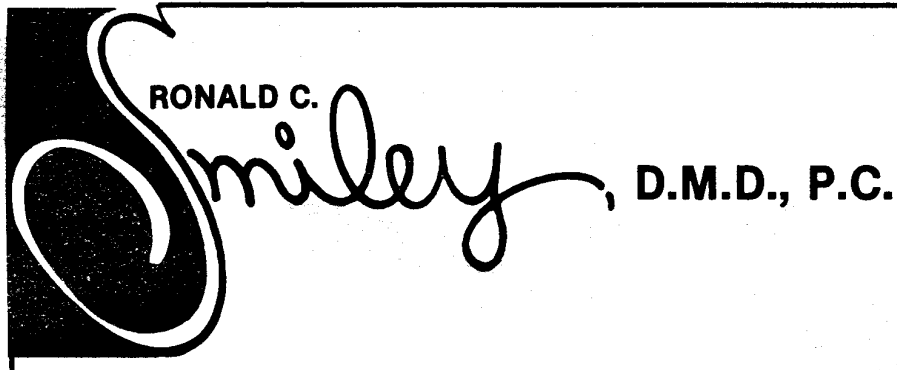
AUTHORIZATION FOR SERVICES AND RELEASE OF INFORMATION

The signature on this form serves as authorization for treatment by Ronald C. Smiley, D.M.D., P.C. I authorize the release of any dental/medical, or other information about me/patient, to my insurance company in order to process this or future claims, or for utilization review or quality assurance. I also authorize Ronald C. Smiley, D.M.D., P.C. to release or receive dental information for the purpose of patient referral. I hereby assign benefits and authorize payment under my insurance program to be paid directly to Ronald C. Smiley, D.M.D., P.C. on any bills for services furnished to me when Ronald C. Smiley, D.M.D., P. C. files my claim. I understand I am financially responsible to the doctor for any balance not covered by my insurance carrier. Regarding dental care to those under age 18, parents or legal guardians are financially responsible for payment.

This signature below serves as authorization for treatment and release of information as detailed above. This signature also acknowledges understanding and compliance with all the above stated policies. I assume financial responsibility for services rendered as detailed on this sheet.

Date _____ Signature _____

A GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE.



PATIENT INFORMATION

Name: _____
Last First Middle Initial How do you wish to be addressed

TODAY'S DATE: _____ BIRTHDATE: _____ AGE: _____ SSN: _____

MALE: _____ FEMALE: _____ SINGLE: _____ MARRIED: _____ CHILD: _____ OTHER: _____

ADDRESS: _____
Street City State Zip code

TELEPHONE: _____
Home Business Cell phone Pager/ other

E-MAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US OR WHOM MAY WE THANK FOR THIS

REFERRAL: _____

EMPLOYER: _____

HOW LONG EMPLOYED: _____ OCCUPATION: _____

INSURANCE COMPANY: _____

NAME OF POLICY HOLDER: _____
Please give card to the receptionist

POLICY HOLDERS: S S Number: _____ DOB _____

FAMILY PHYSICIAN: _____
Name Phone Number

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE NUMBER: _____ RELATIONSHIP: _____



RONALD C.

Smiley, D.M.D., P.C.

DENTAL HISTORY

Date: _____ Name: _____
(Last) (First) (Middle)

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration for your individual needs:

Previous Dentist: _____ Specialty: _____

Period of Treatment: _____ Date of Last Dental Visit: _____

Last Full Mouth X-rays: _____ Last Complete Dental Exam: _____

What is your immediate concern? _____

Please check Yes or No

- 1) Are you presently in pain? Yes___ No___
Teeth ___ Jaw ___ Face ___
Gums ___ Other _____
- 2) Is any part of your mouth sensitive to the following: Yes___ No___
Hot ___ Cold ___ Pressure ___
Sweets ___ Sour ___ Other _____
- 3) Do you have a burning sensation in your mouth? Yes ___ No___
- 4) Are you troubled with dryness in your mouth? Yes ___ No___
- 5) Have you ever had or do you presently have chronic head, neck or back pain problems? Yes ___ No___
- 6) Have you ever had injury, pain, or soreness from your jaw joint? TMJ Dysfunction Yes___ No___
- 7) Have you ever had periodontal treatment or gum surgery? Yes___ No___
- 8) Have you ever been informed that you have or had gum problems? If Yes, when? _____ By whom? _____
- 9) Do your gums bleed when you brush your teeth? Yes___ No___
- 10) Does food catch between your teeth? Yes___ No___
- 11) Are you aware of bad taste or odor in your mouth? Yes___ No___

12) Please indicate which items you use daily:

Hard - bristle toothbrush Proxi – brush Water Spray
 Soft – bristle toothbrush Rubber tip Stimudents or toothpicks
 Electric toothbrush Dental floss Other _____

- 13) Are you aware of any growths or swellings in your mouth? Yes___ No___
- 14) Do you have frequent cold sores, canker sores, or fever blisters on your gums, cheeks, or lips? Yes___ No___
If *YES*, how often? _____
- 15) Are you aware of your jaw clicking, popping or making grating like noises? Yes___ No___
If *YES*, how often? _____
- 16) Do your jaw muscles feel tired, stiff, or painful? Yes___ No___
- 17) Are you aware of clenching your teeth during the day? Yes___ No___
- 18) Have you ever been told you grind your teeth during sleep? Yes___ No___
- 19) Are you dissatisfied with the appearance of your teeth? Yes___ No___
- 20) Do you wear a removable denture or appliance? Yes___ No___
- 21) Are you frustrated by needing constant dental repair because of your active dental disease? Yes___ No___
- 22) Are you anxious about dental treatment? Yes___ No___
- 23) Would you like medication to relax you during your dental appointments? Yes___ No___
- 24) Are you concerned about the finances required to return your mouth to a state of excellent dental health? Yes___ No___
- 25) Do you want to learn to control your dental disease to preserve your teeth and oral health? Yes___ No___



RONALD C.

Smiley, D.M.D., P.C.

HEALTH HISTORY

Please Check YES or NO

If YES Check Those That Apply Where Indicated

- 1) Are you in good health? Yes ___ No ___
- 2) Are you currently under the care of a physician? Yes ___ No ___
- 3) Has there been a change in your health within the past year or have you been hospitalized or had a serious illness within the past 5 years? Yes ___ No ___
- 4) Do you have heart trouble or any form of cardiovascular disease? Yes ___ No ___
 - ___ Angina (chest pains) frequency ___
 - ___ Heart attack date _____
 - ___ Heart surgery date _____
 - ___ Stroke date _____
 - ___ Rheumatic fever date _____
 - ___ Heart murmur _____
 - ___ High or low blood pressure _____
 - ___ Atherosclerosis _____
 - ___ Other _____
- 5) Do you have or have you every had any of the following? Yes ___ No ___
 - ___ Diabetes or Hypoglycemia
 - ___ Kidney disease
 - ___ Liver disease or jaundice
 - ___ Hepatitis: Type: _____
 - ___ Excessive bleeding
 - ___ Psychiatric problems
 - ___ Hip or other joint replacement
 - ___ Allergies (other than medications)
 - ___ Hives or skin rash
 - ___ Thyroid Disease
 - ___ Arthritis
 - ___ Glaucoma
 - ___ Tuberculosis
 - ___ Emphysema or breathing problems
 - ___ Stomach or intestinal disorders
 - ___ Fainting Spells, epilepsy, seizures
 - ___ Sinus trouble
 - ___ Asthma or hay fever
 - ___ Cancer: Type: _____
- 6) Do you have any blood diseases? Yes ___ No ___
 - ___ Anemia
 - ___ Venereal disease
 - ___ Aids or positive test for HIV antibodies
 - ___ Leukemia
 - ___ Other
- 7) Have you ever suffered trauma to your head or neck, such as in a car accident? Yes ___ No ___

8) Have you had surgery, radiation or other treatment for a tumor or growth in the head or neck area? Yes ___ No ___

9) Are you pregnant? Expected delivery date _____ or nursing? Yes ___ No ___

10) Are you allergic to or have you had any unusual reaction to any medications? Yes ___ No ___

If Yes, please list: _____

11) Have you ever been advised not to take a particular medication? Yes ___ No ___

If Yes, please list: _____

12) Have you ever been advised to take prophylactic antibiotics before dental treatment? Yes ___ No ___

13) Please list all of the medications you are currently taking:

Name	Purpose	Frequency	Since

___ Tobacco _____ packs per day for approximately _____ years

___ Recreational drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation.

Signature: _____ **Date:** _____

Print name: _____ **BP** _____ **Pulse** _____

MH Update: _____ **Date:** _____ **BP** _____ **Pulse** _____

MH Update: _____ **Date:** _____ **BP** _____ **Pulse** _____