



**Patient's Name**

Title \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_

Contact: \_\_\_\_\_

H: (\_\_\_\_) \_\_\_\_\_ W: (\_\_\_\_) \_\_\_\_\_

C: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_@\_\_\_\_\_

Single  Married  Divorced  Other

In case of emergency please contact:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Last dental appointment: \_\_\_\_\_ Dentist: \_\_\_\_\_

\*If patient is under 18 years old:

Parent's Name: \_\_\_\_\_  
Title \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Dental Insurance #1:**

Insurer's Name: \_\_\_\_\_ Birthday: \_\_\_/\_\_\_/\_\_\_

SSN: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

\*Other Dental Ins. Coverage: \_\_\_\_\_

**Signature on File**

- 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: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

Please Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

A COPY OF OUR PRIVACY POLICY IS POSTED ON OUR OFFICE WALL FOR YOUR CONVENIENCE, IF YOU WISH TO HAVE A HARDCOPY, PLEASE ASK SOMEONE ON OUR STAFF.

**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.

\*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.

\*I understand that to release my records and x-ray films, a separate consent for release must be signed. A \$20.00 filing and duplication fee will be charged and must be paid in full prior to release.

**Disclaimer:**

I understand that it is my responsibility to keep scheduled appointments. Your Smile requires a 24 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

- |  |   |
|--|---|
| <input type="checkbox"/> AIDS/HIV Positive           | <input type="checkbox"/> Drug/Alcohol Addiction   |
| <input type="checkbox"/> Alzheimer's Disease         | <input type="checkbox"/> Emphysema                |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Epilepsy or Seizures     |
| <input type="checkbox"/> Angina                      | <input type="checkbox"/> Excessive Bleeding       |
| <input type="checkbox"/> Arthritis/Gout              | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Artificial Heart Valve      | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Artificial Joint            | <input type="checkbox"/> Heart Attack             |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Heart Pace Maker         |
| <input type="checkbox"/> Blood Disease               | <input type="checkbox"/> Heart Trouble or Disease |
| <input type="checkbox"/> Blood Transfusion           | <input type="checkbox"/> Hepatitis A B C          |
| <input type="checkbox"/> Blood Pressure: HIGH or LOW | <input type="checkbox"/> Hypoglycemia             |
| <input type="checkbox"/> Breathing Problems          | <input type="checkbox"/> Kidney Problems          |
| <input type="checkbox"/> Cancer/Tumors: _____        | <input type="checkbox"/> Liver Disease            |
| <input type="checkbox"/> Chemotherapy/Radiation      | <input type="checkbox"/> Lung Disease             |
| <input type="checkbox"/> Chest Pains                 | <input type="checkbox"/> Pain in Jaw or Joints    |
| <input type="checkbox"/> Congenital Heart Disorder   | <input type="checkbox"/> Psychiatric Problems     |
| <input type="checkbox"/> Cortisone Medicine          | <input type="checkbox"/> Recent Surgery: _____    |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Rheumatism               |

### 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
- Would you like to speak to the doctor in private:  yes  no

Please list any medications both over the counter and prescription that you are taking:

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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:

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## Dental History

Do you have any present dental complaints?  yes  no \_\_\_\_\_

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

When was your last dental cleaning? \_\_\_\_\_ Where? \_\_\_\_\_

Have you ever had periodontal disease? \_\_\_\_\_ How many times a week do you floss? \_\_\_\_\_ 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 of patient, parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Please do not write below this area, office use only.

Doctor Notes: