Welcome to Smile Creations Dental Practice. Thank you for choosing us to serve your oral health care needs. Please complete the following forms with your information.

Patient Information

First Name ______ Last Name ______ Middle Initial ______ Preferred Name ______

Address ______

City ______ State ______ Zip Code ______

Home Phone ______ Work Phone ______ Cell Phone ______

Date of Birth ______ Social Security # ______ Driver's License # ______

Responsible Party (if different from patient) ______ Relationship ______ Cell Phone ______

Email Address: We send appointment reminders via text and email. CAN-SPAM compliance means you can unsubscribe at a later time. We won't share your information without your consent.

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact

Name ______ Cell Phone ______ Relationship ______

Who May We Thank for Referring you?

☐ My Friend:______________________

☐ My Co-Worker_____________________

☐ My Family Member________________

☐ Other___________________________

I found you on

☐ Google

☐ Walk by

☐ Website

☐ Facebook

☐ Insurance website

☐ Other___________________________

Employment Information (for insurance billing)

Subscriber's Name (policy holder)____________________

Date of Birth ______________________________________

Subscriber ID or Social Security #____________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer ______ ☐ Full Time ☐ Part Time

Address ______

City ______ State ______ Zip Code ______

Insurance Company ______ Group Number ______

Smile Creations Dental Practice -- Please Do Not Copy or Distribute

Smile Creations Dental Practice Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. 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.

Patient Name____ Date of Birth_________________________________

Medical History

Question			
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	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	
Do you have sleep apnea?	Yes	No	If yes, do you have a CPAP or dental device? ________________
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	If yes, ______________________________
Do you need to pre-medicate?	Yes	No	If yes, ______________________________

Women:

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

Are you allergic to any of the following:

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

☐ Other If yes, please explain:____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

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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________________

Smile Creations Dental Practice -- Please Do Not Copy or Distribute

Smile Creations Dental Practice Dental Questionnaire

Patient Name____ Date of Birth______________________________

Dental History

What is your goal for today? ____

When was your last dental visit? _________________Year(s)/Months Ago When was your last dental cleaning? ____________Year(s)/Months Ago

Your past dental experiences were: ☐ Excellent ☐ Great ☐ Fair ☐ Bad

If you had a bad experience, please explain: ____

Do dental procedures make you nervous? ☐ Not nervous ☐ Slightly ☐ Moderately ☐ Extremely

Do you currently have any tooth pain or discomfort? ☐ Yes ☐ No If Yes, how long has it been hurting? ______________________________

Where is the pain? ☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left ☐ Upper Front Teeth ☐ Lower Front Teeth

Does it hurt with (please check all that apply):

☐ Sharp ☐ Biting ☐ Hot ☐ Cold ☐ Sweets ☐ Throbbing ☐ Constantly ☐ Intermittent ☐ Spontaneous ☐ Dull ache

How often to you brush your teeth? ____________times/day How often do you floss? ____________times/day/week

Please check any of the items that you use often in oral care:

☐ Hand Tooth Brush ☐ Electric Toothbrush, Brand_____________________ ☐ Dental Floss ☐ Water Pik ☐ Interproximal Toothbrushes

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever had braces? ☐ Yes ☐ No If yes, when? ______________________________________

Have you ever had an injury to your face of jaw? ☐ Yes ☐ No If yes, when? ______________________________________

Have you ever had clicking near your ear when chewing? ☐ Yes ☐ No If yes, how long? ___________________________________

Do you have sores/blisters near gums, lips, cheeks? ☐ Yes ☐ No If yes, where? ______________________________________

Do you have any loose teeth or broken fillings? ☐ Yes ☐ No If yes, where? ______________________________________

Have you had difficulty getting numb for dental work? ☐ Yes ☐ No

Does dental anesthetic make your heart beat faster? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No If yes, do you currently wear a night guard?_____________________

Smile Analysis

Would you like to have whiter teeth? ☐ Yes ☐ No

Would you like to have straighter teeth? ☐ Yes ☐ No

Do you have dental work that appears unnatural? ☐ Yes ☐ No

Are you self-conscious about your teeth or smile? ☐ Yes ☐ No

Would you like to change anything about the appearance of your teeth or smile? ☐ Yes ☐ No If yes, what would you like to improve? _________

____

I am interested in the following:

☐ Exam/X-rays ☐ Routine Cleaning ☐ Deep Cleaning ☐ Filling(s) ☐ Crown(s) ☐ Dental Implant(s) ☐ Veneers

☐ Teeth Whitening ☐ Clear Correct (clear orthodontic trays) ☐ Cosmetic Consultation ☐ Smile Makeover

☐ Other____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN____DATE_______________

Patient Name____ Date of Birth__________________________________

Please provide a copy of all Dental and Medical insurance card(s) and a Driver's License or Photo ID

Financial Policy and Payment Guidelines

Payment is due at the time services are rendered and this includes all co-payments, deductibles, and co-insurance.

- We accept cash, checks, MasterCard, Visa, Discover, and Care Credit as payment for services rendered.
- We have a returned check policy of $35.00 for any returned checks.
- Accounts are considered past due after 60 days and are subject to interest being added to the balance at the rate of 1 ½% per month (18% annually).
- I understand that payment prior to the treatment day may be requested. This will allow our team to prepare for your upcoming appointment.
- I understand that if I do not cancel my appointment 48 hours in advance of my appointment time, I may be charged a $50.00 cancellation fee.
- **I authorize direct payment of my insurance benefits to Smile Creations Dental Practice for services rendered to myself or my dependents**.

Initials______________

Insurance

Dental insurance may not always cover the full cost of your treatment.

- In these instances, our patients are responsible for financing some of or all their dental treatment themselves.
- If you would like our office to bill your insurance company, you will need to provide us with the necessary information to process the claim.
- Policies vary, and we strive to help you get the maximum benefits from your insurance.
- Please keep in mind that you are responsible for your total dental treatment plan costs.
- Should your insurance benefits result in less coverage than anticipated, you are responsible for the difference in payment.
- Your insurance policy is a contract between you and your insurance company. As a dental care provider, we are not a party to that agreement.
- **We must collect your estimated co-pays and/or deductibles** as required by insurance company policy and California State Law.
- **You are responsible for all unpaid fees for services rendered**, regardless of what the insurance company chooses to reimburse or deny.
- While we may check your eligibility and benefits as a courtesy to our patients, **it is your responsibility to monitor and maintain the status of your insurance policy.**
- If your dental insurance company or your address changes, you are responsible for notifying us of these changes.

Initials_____________

Late/Cancellation/No Show Policy

- LATE: We understand that delays can happen, however, we must keep the other patients and providers on time. If a patient arrives 15 minutes past the scheduled appointment time, we may need to reschedule the appointment to a later time or day as we need all of the scheduled time to complete your procedure. You may be subject to the $50.00 no show fee.
- CANCEL: We request that you give our office a 48-hour's notice in the event you need to cancel or reschedule your appointment. If you do not contact our office, we will consider this to be a No Show to your appointment.
- We understand that there are times when you must miss your appointment due to an emergency or obligation to family or work, however if you do not call to cancel your appointment, you may be preventing another patient from getting needed treatment.
- Excessive cancelled or no-show appointments may result in you being dismissed from the practice.
- **If we do not receive a call 48-hours in advance, you may be charged a no-show fee of $50.00. More than three no shows may result in you being dismissed from the practice**.
- As a courtesy, we provide an appointment card, a reminder call, text message, and/or email reminder for appointments. If you do not receive your reminder call, message, text, or email, the cancellation policy still remains in effect. *You are responsible for remembering your appointment*. If you have any questions regarding our policy, please ask one of our team members.

I would like appointment reminders by (check all that apply):

☐Text to phone __________________________ ☐Email reminders to_____________________________ ☐Phone call to phone # ______________________

Dentists and the Telephone Consumer Protection Act: I consent to the dental practice using my cell phone number to call or text regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

I have read and understand the Late/Cancellation/No Show Policy and agree to the terms. Initials_____________

Optional Authorization for Release of Dental Information to Others

I give my consent to Smile Creations Dental Practice to discuss my dental treatment, finances, insurance, appointments to the person I list below. In case of a minor, I authorize the release of information regarding my child to the person listed below. This authorization remains in effect until I provide written notification to update the changes.

Name____ Relationship_________________________________ Phone_____________________________

OR ☐ Do Not Release Information

Privacy Practices

All patient information is kept private and confidential per the Health Insurance Portability and Accountability Act (HIPPA).

- Occasionally we need to communicate with other dentist(s) we refer you to or with the dental lab if we need to send your case out. I give my consent to have photos taken which may be used as anonymous before and after examples or to communicate with the dental lab. I give my permission to Smile Creations Dental Practice to leave a detailed message on my voicemail/text/ or with the person answering the phone regarding future appointment dates and times.
- We are making available to you a copy of our Notice of Privacy Practices.

Dental Materials Fact Sheet

I have reviewed the State of California Dental Materials Fact Sheet as required by law.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN____DATE_____________________

Smile Creations Dental Practice

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

- ☐ Payment by cash
- ☐ Payment by check. Returned checks are subject to a $35.00 processing fee.
- ☐ Payment by Visa, Mastercard, or Discover Card
- ☐ Automatic monthly billing to your Visa or Mastercard. This will require a down payment and be charged APR of 12%.
- ☐ Care Credit Financing (6 months no interest or 24 months with 14.9% interest – rates may change as set by Care Credit)
- ☐ Guarantee any amount not covered by insurance with Visa, Mastercard, or Discover Card

Please make your choice, sign below, and return to front office staff before treatment.
Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa or Mastercard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see our front office staff. Thank you.

Printed Name ____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN____DATE_________________