Designer Smiles Dentistry

WELCOME!

Patient Information

Patient's Name: MR./ MRS./ MS./ DR.

(Last)_____(MI)_____(First)_____

Address:_____ City _____ Zip Code _____

DOB: _____/_____/_____ Social Security Number: _____

Employer: _____ Occupation: _____

Business Address:_____

Home Phone Number: (_____)_____ Mobile: (_____)_____

Email Address:_____

How did you learn about us?_____

Reason for today's visit: _____

Continue Below *Only* If You Have Dental Benefits

Subscriber's Info:

Name (Last) _____ (MI)_____ (First)_____ DOB:_____/_____/_____

Address_____

Employer_____

Please Circle: Social Security# or Member ID#_____ Group/Policy#_____

Insurance Company's Info:

Insurance Company Name _____

Dental Claim Mailing Address_____

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Dental History

Patient's Name: (Last)_____(MI)_____(First)_____

What is your immediate dental concern? _____

What are you long term dental goals?_____

Have you been satisfied with your previous dentistry? □ Yes □ No

Have you had any bad experiences? Elaborate_____

Most recent dental exam? _____/_____/_____

Most recent dental x-rays? _____/_____/_____

How often do you have your teeth cleaned? □ 3 months □ 4 months □ 6 months □ 12 months □ longer_____

How would you describe your current dental health?_____

Please answer Yes or No to the following and provide any additional information in the explain section

□ Yes □ No Do you have any particular dental fears? Explain _____

□ Yes □ No Problems with effectiveness or bad reaction to dental anesthetic?_____

□ Yes □ No Periodontal treatment? (Gum) When _____

□ Yes □ No Bleeding Gums

□ Yes □ No Part of your mouth sensitive to temperature

□ Yes □ No Sore teeth?

□ Yes □ No Difficulty swallowing?

□ Yes □ No Unpleasant odor or taste in your mouth?

□ Yes □ No Jaw problems (TMJ Disorder)?

□ Yes □ No Do you wear or have you ever worn a nightguard or occlusal appliance?

□ Yes □ No Difficulty in opening your mouth widely?

□ Yes □ No Clench or grind your teeth?

□ Yes □ No Jaw clicking or popping?

□ Yes □ No Lost any teeth?

□ Yes □ No Do you experience anxiety at the dental office?

□ Yes □ No Have you ever had a dental emergency? Explain _____

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Please select an answer for each of the following.

Are you allergic to any of the following?
□ Yes □ No Aspirin
□ Yes □ No Ibuprofen
□ Yes □ No Acetaminophen
□ Yes □ No Penicillin/Amoxicillin
□ Yes □ No Erythromycin
□ Yes □ No Tetracycline
□ Yes □ No Codeine
□ Yes □ No Local Anesthetics
□ Yes □ No Fluoride
□ Yes □ No Metals (gold stainless steel, _____)
□ Yes □ No Latex
□ Yes □ No Any other medication _____
□ Yes □ No Are you required to take pre-medication before dental treatment? If yes, for what condition
_____

Female:
□ Yes □ No Taking birth control
□ Yes □ No Pregnant

Male:
□ Yes □ No Prostate disorders

Name of Physician _____
Most recent Physical_____

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

Please list ALL medications you are currently taking.

1._____

2._____

3._____

Do you have any of the following conditions?

□ Yes □ No Heart problems
□ Yes □ No Heart murmur
□ Yes □ No Rheumatic fever
□ Yes □ No High blood pressure
□ Yes □ No Low blood pressure
□ Yes □ No History of a stroke
□ Yes □ No Artificial prosthesis (i.e. heart valve or joints)
□ Yes □ No Anemia
□ Yes □ No Prolonged bleeding due to slight cut
□ Yes □ No Emphysema
□ Yes □ No Tuberculosis
□ Yes □ No Asthma
□ Yes □ No Sinus problems
□ Yes □ No Kidney disease
□ Yes □ No Liver disease
□ Yes □ No Jaundice
□ Yes □ No Thyroid or parathyroid disease
□ Yes □ No Arthritis
□ Yes □ No Glaucoma
□ Yes □ No Diabetes
□ Yes □ No Stomach or Duodenal ulcer
□ Yes □ No Digestive disorders
□ Yes □ No Epilepsy or convulsions (seizures)
□ Yes □ No Hepatitis (type_____)
□ Yes □ No HIV/AIDS
□ Yes □ No Radiation therapy
□ Yes □ No Chemotherapy
□ Yes □ No Tumor or abnormal growth
□ Yes □ No Any lumps or swelling in the mouth
□ Yes □ No Hives, skin rash, hay fever
□ Yes □ No Alcohol or Drug Dependency
□ Yes □ No Are you presently being treated for any illness?
□ Yes □ No Aware of changes in your general health
□ Yes □ No Often exhausted or fatigued
□ Yes □ No Subject to frequent headache
□ Yes □ No Heavy smoker (1 or more packs a day)
□ Yes □ No Head or neck injuries

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

X Signature _____ **Date** _____

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient's Name: (Last)_____(MI)_____(First)_____

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Designer Smiles Dentistry, PLLC is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our dental office, its dental staff, and all affiliated health care providers that jointly perform payment activities and business operations with our dental office, "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

_____ (**Initial**) By signing below you acknowledge that you have received a copy of the Notice of Privacy Practices. This Acknowledgement form will become a part of your permanent medical record.

X Signature _____ **Date** _____

Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

This office also reserves the right to charge a fee of $50 for any missed appointment without a 24 hour prior notice. This fee will be due immediately prior to the next appointment date.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within 5 days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due, I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

_____ (**Initial**) I have read the above conditions of treatment and payment and agree to their content.

X Signature _____ **Date** _____