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NEW PATIENT INFORMATION FORM

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICK NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ SS #: _____

DOB: ____/____/____ MARITAL STATUS: _____ SEX: _____

EMPLOYER NAME AND ADDRESS: _____

REFERRING DR: _____ REFERRING PT: _____

MEDICAL ALERTS: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS# or ID #: _____ DOB: ____/____/____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS# or ID #: _____ DOB: ____/____/____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

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Insurance and Credit

1. I understand that insurance coverage is estimated. The actual reimbursement may be less. I, the patient or responsible party if patient is a minor am responsible for all amounts not covered by my insurance carrier. I also understand that it is my own responsibility to know what my insurance plan covers including deductibles, yearly maximum amounts.

2. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

3. I understand that payment is due at the time of services unless other arrangements have been made. If any form of credit is to be given, I authorize Smiles of Distinction to draw a credit report. Upon the credit report review, I understand that it is at the discretion of Smiles of Distinction weather or not me or my family members receive any form of credit. In the event payments are not received by agreed upon dates I understand that a late charge and finance charges may be added to my account.

4. Attorney and collection fees insured in an effort to enforce payment will be paid by me or responsible party, whose failure to pay, required said costs and services to be incurred.

5. I herby understand that failure to sign such service contract does not negate the responsible to treatment implies consent as outlined in this service agreement.

6. I have read, understand and agree to all of the above, I hereby understand that I may have a full recital of all fees to my account, simply by asking.

Patient or Responsible Party Signature:_____ **Date:**_____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices
(Patient first name)

_____
Print Name

_____
Signature

_____
Date

_____
FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications Barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify):

_____
_____
_____

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Date of last dental visit?_____ Last Cleaning visit?_____

How often do you brush your teeth?_____ How often do you floss?_____

Are your teeth sensitive to: Hot Cold Sweets Biting/Chewing

Have you notices bad tastes or mouth odors? YES NO

Do you frequently get cold sores, blisters, or any other oral lesion? YES NO

Do your gums bleed or hurt? YES NO

Have you noticed a change in your bite? YES NO

Does food get caught between your teeth? YES NO

Do you clench or grind your teeth? YES NO

Do you mouth breathe when sleeping or awake? YES NO

Have tired jaws, especially in the morning? YES NO

Snore or have been diagnosed with sleep apnea? YES NO

Are you happy with how your teeth look? YES NO If no, what would you change?_____

_____

_____

Are you nervous about having dental treatment? YES NO

Is there anything else you'd like to share regarding your dental health or experiences?

_____

_____

_____

SEDATION · FAMILY · COSMETIC

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PATIENT MEDICAL HISTORY

Patient's Name:

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ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)