SMILEHAVEN DENTAL CENTER
Patient Information

General Patient Information

First Name _____ Middle Initial _____ Last Name _____

Gender _____ Male _____ Female Marital Status _____ Single _____ Married _____ Divorced _____ Widowed

Social Security Number _____ - _____ - _____ Date Of Birth _____ / _____ / _____ Age _____

If a minor, give name of parent / legal guardian _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Driver's license # _____

Employed By _____ Occupation _____

Medical Doctor _____ Phone # _____

In case of emergency, contact #1_____ Phone # _____

#2_____ Phone # _____

Former Dentist _____ Phone # _____

Dental Plan _____ Group # _____ Phone # _____

Subscriber Name _____ I.D. _____ SS# _____-____-_____ DOB _____ / _____ / _____

Reason for
Visit:_____

HIPAA Consent and Acknowledgement Form

I understand that as part of my healthcare, SmileHaven Dental Center originates and maintains health records describing my health history, symptoms, examination, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication with health professionals who contribute to my care.

I,(Patient Name-Print) _____do hereby consent and acknowledge my agreement to the terms set forth in the “HIPAA Information Act" and office privacy policy. I authorize the release of my health records and/or my legal dependent's healthcare records to other healthcare professionals and insurance providers involved in my/their care. I understand that this consent and acknowledgement shall remain in force indefinitely.

_____ Date:_____
Signature of Patient or Guardian

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Medical History

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

Please answer the following questions: **Circle "Y" Yes or "N" No**			**If Yes, please explain**
Are you under a physician's care now?	Y	N	_____
Have you been hospitalized or had major surgery (eg. arm, knee, hip, implants)?	Y	N	_____
Have you had Heart Surgery? Stent? Artificial Valve? Pacemaker?	Y	N	_____
Do you require antibiotics (pre medication) for dental treatment?	Y	N	_____
Are you taking any medications or drugs? *Provide a list medications	Y	N	_____
Do you take or have you taken Phen-Fen or Redux?	Y	N	_____
Are you taking or have you taken bisphosphonate (eg. Fosamax, Boniva)?	Y	N	_____

Do you smoke? Y__ N__How much per day?_____

Allergies: Are you allergic to any of the following? Have you had Hives: ___Y___N or Anaphylactic Shock: ___Y___N

___ Aspirin ___ Penicillin ___ Tetracycline ___ Latex ___ Other _____
___ Codeine ___ Erythromycin ___ Sulfa Drugs ___ Iodine _____

Women only: Are you pregnant or think you're pregnant? Y N How Many Months_____
Are you taking birth control pills? Y N _____

Do you have or have you had any of the following: Please MARK all Y (yes) or N (no).

__ Aids / HIV	__ Blood Transfusion	__ Emphysema	__ Herpes	__ Renal Dialysis
__ Anemia	__ Bruise Easily	__ Epilepsy /Seizures	__ High Blood Pressure	__ Rheumatic Fever
__ Angina	__ Cancer / Chemotherapy	__ Fainting Spells	__ Jaundice	__ Shingles
__ Apnea/Sleep	__ Cerebral Palsy	__ Glaucoma	__ Knee Replacement	__ Stroke
__ Arthritis/Rheumatism	__ Congestive Heart Failure	__ Heart Attack	__ Kidney Disease	__ Thyroid Problems
__ Artificial Heart Valve	__ Convulsion	__ Heart Murmur	__ Liver Disease	__ Tuberculosis
__ Artificial Joint	__ Cortisone Medicine	__ Heart Pacemaker	__ Mental Disorder	__ Ulcers
__ Asthma	__ Diabetes Type 1 or 2	__ Hemophilia	__ Mitral Valve Prolapse	__ Venereal Disease
__ Blood Disease	__ Drug Addiction	__ Hepatitis A/B/C	__ Osteoporosis	

List any serious medical condition(s) that you have ever had, that is not listed above:

_____

Have you ever had a local anesthetic (eg. lidocaine, carbocaine) ? ___ Yes ___ No
Have you ever had any unfavorable reaction to the local anesthetic ? ___ Yes ___ No
Any serious trouble with previous dental visits? _____

To the best of my knowledge, I have answered these questions accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

Consent of treatment: I hereby grant authority to SmileHaven Dental Center and staff to take all necessary x-rays, to perform visual exams and prophylaxis as may deemed necessary or advisable for my diagnosis and treatment.

Patient Signature _____ Date _____ Relationship _____

Doctor's Signature _____ Date _____

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Financial Terms and Conditions:

Thank you for choosing SmileHaven Dental Center as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance forms before seeing the doctor. Acceptable forms of payment are *CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & CARE CREDIT.* You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

SMILEHAVEN DENTAL WELLNESS CLUB OPTION: For patients without dental insurance our office provides a prepaid membership program which has a set of covered services and discounts for non covered services. Please ask our staff for the brochure that details the costs, services and discounts included. To receive the benefits of SmileHaven Dental Club you must become a member and have all membership fees paid in full prior services. SmileHaven Dental Club can not be used with any other discounts or insurance plans.

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ESTIMATED co-payment on the day services are rendered. We will gladly file your insurance claim. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company but, we do not do coordination of Insurance benefits. Billing of secondary insurance is the sole responsibility of the Patient. Payment in full will be expected at the time of service. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Care Credit, or payment by cash or check at time of service has been verified.

GENERAL: As a condition of my treatment by this office, I understand that a written plan will be provided to me outlining the procedures, costs and any estimated co payments due. I understand the fee estimate quoted can only be extended for a period of six months from the date of the examination. I understand that financial arrangements must be made in advance and must be paid prior to the work being performed. I acknowledge the practice depends upon reimbursement from the patient for the costs incurred in their care. I acknowledge checks returned due to insufficient funds - there will be an additional charge of $35.00 plus collection costs.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balances past due. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to have photos taken of me to be used for education, training and/or marketing. I further agree that in the event that either this office or I, institute any legal proceedings with respect to the amount owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fee.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

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Office Policies

- Hours of Operation: Monday - Friday 9 am -5 pm.
- All patients must fill out and sign the Health and Financial intake forms prior to seeing the dentist.
- For our safety and yours, our office is following ADA, PPE protocols.
- Due to COVID 19, for the safety of all in our office, we require you to wear a mask as you enter the dentist office and while you are in the waiting room. Also you will need to comply with temperature taking and screening questions. If your temperature is above 99.8 degrees, even though you may feel well, your appointment will be rescheduled.
- Individuals other than the patient being seen are normally not allowed in the operatory. (exceptions made only with dentist's approval).
- Patients under the age of 18 must have a parent or guardian in the waiting room until treatment is completed.
- Separate appointments may be necessary for diagnosis and treatment.
- ***X-Rays***: Necessary X-Rays are required for first time patients, unless the patient doesn't have any teeth. Upon request X-Rays can be sent to another office digitally by email or Xerox copies by mail. Note: there will be a charge depending on the number of copies and postage. X-Rays received with a free consultation are used by our office for your diagnosis and treatment. If you request complementary X-Rays to be sent to another dental office prior to treatment received, you will be charged for the full cost of the X-rays taken.
- ***Appointments:***
    - *Patients arriving 10 minutes late may be subject to being rescheduled. Please be on time or 5 minutes early so we can better serve you.*
    - *Cancelled or "No Show" visits without 24 hours' notice will be charged $25.00 per half hour. Patients with insurance will be charged in accordance to their insurance plan coverage.*
    - *Appointments scheduled in combination with the Doctor and Hygienist that are "No Shows" will be charged as separate appointments and will not be rescheduled in combination for future appointments.*
    - *Patients who "No show", cancel or reschedule their appointment three times without 24 hours' notice will be transferred out of the dental practice.*
- ***Dental Records:*** If you want a copy, you will need to sign a release and pick it up from the office. If you send in a signed authorization we can email them to the provider. There will be a 25 cent charge per page.
- The only ***animals*** allowed in the office are official service animals, seeing eye dogs and dogs who are trained to know if you are having a specific medical emergency. We love animals and know how important they are but they can not be in the operatories where surgeries are performed (per ADA Guidelines). So please leave your precious animal at home or have someone with you who can watch them during your dental appointment.
- 0ur employees will treat all patients kindly and with respect. *(If you feel you have not, **please** bring it to our attention)*. If a patient chooses to behave in a disrespectful manner they will be asked to leave and possibly asked not to return. Any acts of violence, physical or verbal, will be prosecuted to the full extent of the law.
  We reserve the right to refuse service at any time.

I have read the above Office Policies and I agree to their content.

Signature of Patient or Guardian_____ Date_____

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Health Questionnaire & Wellness Services

SmileHaven Dental Center is a Whole Body Health Dental practice. About 80% of diseases occurring in the human body originate from the mouth. Every tooth in the mouth has a direct correlation to a certain part of the body. Since we deal with whole body health, we also offer our patients education and counseling on how to become optimally healthy as part of our service!

Dr. Chan is also a Certified Fitness Trainer and Health Coach. Our office RN Carol Anne Chan has a Masters in Public Health and is a Certified Health Coach as well. All of our dental patients get one free Health Coaching session. Our Health Coaching sessions are available to anyone, not just dental patients, who are interested in achieving optimal health. The office provides circulation therapies for the whole body and specific localized areas. 97% of diseases are due to micro-circulation issues. We provide a free consultation on Blood Flow and Microcirculation. Our office offers counseling in Detoxing and Detox therapies. We offer a free introductory therapy of your choice. Our therapies include: BEMER, IFR Sauna and Ozone insufflations. Our Nurse can consult with you regarding nutrition goals, weight management and introduce you to healthy clean, Paleo, Keto or intermittent fasting diet strategies, essential oils, medicinal mushrooms and supplements that can help you achieve Optimal Health. They can also direct you to other practitioners, such as MD's, Chiropractors, Cranial Chiropractors, Naturopaths, and Osteopathic DOs, Acupuncturists, etc...who do Functional Holistic medicine.

In order to better serve you, please answer the following questions:

Do you have chronic or serious health issues ie. diabetes, Hypertension, high cholesterol, etc?	___ Yes	___ No
Are you a cancer survivor? With or without a weight problem?	___ Yes	___ No
(There is a 20% increased risk of CA recurrence when overweight.)		
Do you have chronic discomfort? Joint pain, Arthritis, RA, Fibromyalgia?	___ Yes	___ No
Do you have trouble sleeping, foggy memory, lack of energy?	___ Yes	___ No
Would you like a consultation regarding weight management?	___ Yes	___ No
Would you be interested in how you can have Optimal Health with better circulation?	___ Yes	___ No
Have you been exposed to Mold, or environmental toxins? Have Questions on Detoxing?	___ Yes	___ No
Do you think you are electrically or EMF sensitive? Ringing in ears, brain fog, insomnia?	___ Yes	___ No
Do you snore, mouth breath, stop breathing, fall asleep during the day or while driving?	___ Yes	___ No
Do any of your children, snore, mouth breath, wet the bed, have attention difficulties?	___ Yes	___ No

Would you be interested in any of these services?:

Nutrition Counseling $35/hr.	___ Yes	___No	Weight Management Counseling $35/hr.	___ Yes	___ No
Detox Counseling $35/hr.	___ Yes	___No	Circulation Therapy $25 per session	___ Yes	___ No
Supplement Counseling $35/hr.	___ Yes	___No	BEMERs are also for rent $150 a week	___ Yes	___ No
Infrared Sauna $1 dollar/min	___ Yes	___No	Complete a 60 day Health Challenge $50	___ Yes	___ No
Ozone Therapy $10 - $25	___ Yes	___No	Antioxidant Scan $25 for 1, $50 for 3	___ Yes	___ No

Products at Office:

Chlorella	$25	Tooth & Gum Tonic	$25	* Other supplements, essential oils and
K2/D3 5000mg	$30	Revitin Toothpaste	$15	mushrooms can be ordered on request.
CoQMax Omega	$50	Detox Shake	$60	* RF EMF mitigation products available for your
Nano Zeolite Spray	$45	Liposomal Glutathione	$45	cellular devices can be ordered on request.

If you answered Yes, Please Provide the following information:

Name _____
Best Telephone # _____
Best Time to reach you:_____
Email Address_____