# NEW PATIENT INFORMATION

SmileHaven Dental Center

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. | Patient's First Name | (Nickname) | Middle | Last |
| Social Security # | Birth Date (month/day/year) / / | Sex ❑ M ❑ F | Marital Status (circle one) Single / Married / Divorced / Separated / Widowed | |
| Mailing Address | Unit | City | State | Zip Code |
| Email Address | Mobile Phone Number ( ) | Home Phone Number ( ) | | |
| Employer/ School Name (if student) | Employment Status ❑ Full-Time ❑ Part-Time | Work Phone Number ( ) | | |
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. | Spouse's First Name | (Nickname) | Middle | Last (please leave blank if none) |
| How would you prefer to be contacted? (we may contact you about your appointments/care) | When is the best time to reach you? | | | |

## HOW DID YOU HEAR ABOUT US?

Please check one of the following options:

☐Patient Referral
- ☐Employee
- ☐Friend

Name: _____

☐Insurance Plan
Ins: _____

☐Social Media
- ☐Facebook
- ☐Instagram

☐Google/Internet Search
☐Flyer/Mailer
☐Health Fair
☐Employer HR Notice or Event

☐Walk-In
☐Billboard/Ad
☐Other
_____

## RESPONSIBLE PARTY/ GUARDIAN INFORMATION

(if different from you or your spouse)

| | | | | |
|---|---|---|---|---|
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. | Guardian's First Name | (Nickname) | Middle | Last |
| Social Security # | Birth Date (month/day/year) / / | Sex ❑ M ❑ F | Relationship to Patient | |
| Email Address | Mobile Phone Number ( ) | Is this person a patient in our office? ❑ Yes ❑ No | | |

## PRIMARY INSURANCE INFORMATION

Please provide your current insurance card with your completed paperwork.

| | | | | |
|---|---|---|---|---|
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. | Primary Insured's First Name | Middle | Last | |
| Social Security # or Subscriber ID | Birth Date (month/day/year) / / | Sex ❑ M ❑ F | Relationship to Patient | |
| Insured Employer | Insurance Company | Group # | | |

## SECONDARY INSURANCE INFORMATION

(if applicable)

| | | | | |
|---|---|---|---|---|
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. | Secondary Insured's First Name | Middle | Last | |
| Social Security # or Subscriber ID | Birth Date (month/day/year) / / | Sex ❑ M ❑ F | Relationship to Patient | |
| Insured Employer | Insurance Company | Group # | | |

## PATIENT DENTAL / ORAL HEALTH HISTORY

| Reason for Today's Visit: ☐ Check-up ☐ Cleaning ☐ Toothache ☐ Emergency (Please explain): | Date of Last Dental Visit: / / | Date of Last Oral Cancer Screening: / / |
|---|---|---|
| Reason for Leaving Your Previous Dentist: | Name & Location of Previous Dentist: | |

Are you experiencing any of the following? (please check any of the boxes below that apply to you)

| | | |
|---|---|---|
| ❑ Sensitivity (hot, cold, sweet) | ❑ Bleeding, swollen or irritated gums | ❑ Clicking or popping in the jaw |
| ❑ Pain or discomfort | ❑ Head, neck or jaw pain (or injuries) | ❑ Clenching or grinding of your teeth |
| ❑ Loose or broken teeth, fillings and crowns | ❑ Sores or lumps near your throat or mouth | ❑ Bad breath or bad taste in your mouth |

Do you have or have you had any of the following? (please check any of the boxes below that apply to you)

| | | |
|---|---|---|
| ❑ Ortho treatments, such as braces or a retainer | ❑ Dentures or partial dentures | ❑ Periodontal (gum) treatments |

If you could whiten your teeth for a cost anyone could afford, would you do it? ❑ *Yes* ❑ *No*

Do you smoke or use chewing tobacco? ❑ *Yes* ❑ *No* If yes, how much and for how long?

If you could adjust your smile, you would want? (please check any of the boxes below that apply to you)

| | | |
|---|---|---|
| ❑ Brighter/whiter teeth | ❑ Straighter teeth | ❑ Close spaces |
| ❑ Replace metal fillings | ❑ Repair chipped teeth | ❑ Replace missing teeth or old crowns |

On a scale of 1 – 10, with 10 being the highest rating:

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| How important is your oral health to you? (circle one) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| How would you rate the status of your oral health? (circle one) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your visit today?

## PATIENT SLEEP HISTORY

Please check the box if you currently have or have ever had any of the following conditions or behaviors:

| | | |
|---|---|---|
| ❑ Feeling tired or sluggish during day | ❑ Snoring (or being told you snore) | ❑ Difficulty breathing while you sleep |
| ❑ Frequent naps during day | ❑ Using or ever have used a CPAP | ❑ Would you be interested in a complementary sleep diagnostic study? |

## EMERGENCY AND PHYSICIAN CONTACT INFORMATION

| Name of Emergency Contact | Relationship to Patient | Contact Phone Number ( ) |
|---|---|---|
| Name of Primary Physician | Physician Office Location | Physician Phone Number ( ) |
| Name of Preferred Pharmacy | Location | Phone Number |

# PATIENT MEDICAL HISTORY

Are you currently under the care of a physician? ❑ *Yes* ❑ *No* If yes, please describe below:

Are you taking any medications including non-prescription medicine? ❑ *Yes* ❑ *No* If yes, please list medications you are taking and why:

Are you required to take pre-medication prior to dental treatment? ❑ *Yes* ❑ *No*

Have you had an allergic or adverse reaction to any medication or substance, including food? ❑ *Yes* ❑ *No*

Have you had any serious illness, an operation or hospitalization in the last 5 years? Or have there been any recent changes in your general health? ❑ *Yes* ❑ *No*
If yes, please explain:

| *Women only:* | *Are you pregnant or nursing?* ❑ *Yes* ❑ *No* | *Are you taking birth control pills?* ❑ *Yes* ❑ *No* |
|---|---|---|

## PLEASE CHECK THE BOX IF YOU CURRENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS OR BEHAVIORS:

(please provide comments for any boxes checked below)

- ❑ Abnormal bleeding
- ❑ Alcohol abuse
- ❑ Anemia
- ❑ Anxiety
- ❑ Angina pectoris
- ❑ Arthritis
- ❑ Artificial or replacement bones/joints
- ❑ Artificial heart valve
- ❑ Asthma
- ❑ Bio phosphate usage
- ❑ Bleeding problems
- ❑ Blood disease
- ❑ Blood transfusion
- ❑ Cancer - chemotherapy
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Congenital heart defect/lesions
- ❑ Cortisone treatments
- ❑ Cosmetic surgery
- ❑ Cough, persistent or bloody
- ❑ Diabetes Type: _____
- ❑ Difficulty breathing, persistent
- ❑ Drug abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness spells
- ❑ Fever blisters
- ❑ Frequent headaches
- ❑ Glaucoma
- ❑ Hay fever
- ❑ Heart attack
- ❑ Heart murmur
- ❑ Heart surgery
- ❑ Other heart issues: _____
- ❑ Hemophilia
- ❑ Hepatitis type: _____
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Lung disease
- ❑ Mitral valve prolapse
- ❑ Organ transplants: _____
- ❑ Pace maker
- ❑ Phen-fen
- ❑ Pneumocystis
- ❑ Psychiatric problems
- ❑ Radiation therapy
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Seasonal allergies
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle cell
- ❑ Sinus problems
- ❑ Skin rash
- ❑ Sleep apnea
- ❑ Stroke
- ❑ Surgeries: _____
- ❑ Swelling of feet/ankles
- ❑ Swollen glands
- ❑ Thyroid problems
- ❑ TMD or TMJ
- ❑ Tobacco usage (smoking and smokeless)
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Weight loss (unexplained)
- ❑ Yellow jaundice
- ❑ Other (please list):

## PLEASE CHECK THE BOX IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Aesthetics
- ❑ Penicillin
- ❑ Jewelry
- ❑ Latex
- ❑ Metals
- ❑ Other (please list):
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Erythromycin

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my insurance benefits be paid directly to the dentist. I also authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to my child or me during the period of such dental care to third party payer/and or health practitioners.*

_____ _____

*Patient Signature* *Date*

_____

Dentist Signature

# SUMMARY OF POLICIES

*Thank you for choosing Smile Haven Dental Center as your dental care provider. It is very important for us to establish a relationship with you that provides the very best care in the best environment possible. To ensure a mutual understanding, please read a brief description of the policies in place in our office. A detailed version of each policy is available to you upon request.*

## FINANCIAL POLICY

To plan for your dental care, we offer several options. We accept cash, checks, Visa, MasterCard, American Express and Discover, as well as third-party financing options. For unaccompanied minors, we ask that financial arrangements be made prior to the day of their appointment.

As a courtesy to our patients with dental insurance, we will be happy to file insurance claims on your behalf to help you maximize your benefits. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment. We will estimate your insurance coverage and estimate your portion for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due, or we may issue you a credit or a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility, regardless of your insurance carrier's coverage.

## BROKEN APPOINTMENT POLICY

Please help us serve you and all our patients best by keeping your scheduled appointment. If it is necessary to reschedule an appointment, we ask that you give us at least 48 hours' notice to avoid a minimum fee of $75 per reserved hour.

## SUMMARY OF 'NOTICE OF PRIVACY PRACTICES'

We keep a record of every visit you make to our office, and we are committed to protecting the health information that is in that record. Typically, the record contains information regarding your health and dental health along with our professional impression, diagnosis, and treatment. The record belongs to Smile Haven Dental Center, but the information in the record is yours.

The Smile Haven Dental Center 'Notice of Privacy Practices' is a detailed explanation of how we may use your health information and your right to inspect, copy and/or amend what is recorded. We are required by law and by our own code of ethics to keep this information about you private, to give you a copy of this 'Notice' and to follow the practices outlined in the 'Notice'.

Please list others, if any, that we may communicate with regarding your health information and/or treatment:

_____

**You have a right to a copy of this 'Notice'. Please check your option below:**

❑ I am requesting a copy of the Smile Haven Dental Center I 'Notice of Privacy Practices'.

❑ I do not wish to receive a copy of the Smile Haven Dental Center I 'Notice of Privacy Practices' currently, but I reserve the right to request one later.

*I have read, understand and agree to the abovementioned policies. I understand that I may request a copy of a detailed version of each policy.*

_____

*Patient Name (please print)*

_____

*Patient Signature*

_____

*Date*