

NEW PATIENT INFORMATION



PATIENT INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Patient's First Name (Nickname)		Middle	Last
Social Security #		Birth Date (month/day/year) / /		Sex <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Work Phone Number ()	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> 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:

<input type="checkbox"/> Patient Referral <input type="checkbox"/> Employee <input type="checkbox"/> Friend Name: _____	<input type="checkbox"/> Social Media <input type="checkbox"/> Facebook <input type="checkbox"/> Instagram <input type="checkbox"/> Google/Internet Search	<input type="checkbox"/> Walk-In <input type="checkbox"/> Billboard/Ad <input type="checkbox"/> Other _____
<input type="checkbox"/> Insurance Plan Ins: _____	<input type="checkbox"/> Flyer/Mailer <input type="checkbox"/> Health Fair <input type="checkbox"/> Employer HR Notice or Event	

RESPONSIBLE PARTY/ GUARDIAN INFORMATION

(if different from you or your spouse)

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

PRIMARY INSURANCE INFORMATION

Please provide your current insurance card with your completed paperwork.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Primary Insured's First Name		Middle	Last
Social Security # or Subscriber ID		Birth Date (month/day/year) / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient
Insured Employer		Insurance Company			Group #

SECONDARY INSURANCE INFORMATION

(if applicable)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Secondary Insured's First Name		Middle	Last
Social Security # or Subscriber ID		Birth Date (month/day/year) / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient
Insured Employer		Insurance Company			Group #

PATIENT DENTAL / ORAL HEALTH HISTORY

Reason for Today's Visit: <input type="checkbox"/> Check-up <input type="checkbox"/> Cleaning <input type="checkbox"/> Toothache <input type="checkbox"/> Emergency (Please explain):	Date of Last Dental Visit: / /	Date of Last Oral Cancer Screening: / /
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Reason for Leaving Your Previous Dentist:	Name & Location of Previous Dentist:
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Are you experiencing any of the following? (please check any of the boxes below that apply to you)

- | | | |
|---|---|--|
| <input type="checkbox"/> Sensitivity (hot, cold, sweet) | <input type="checkbox"/> Bleeding, swollen or irritated gums | <input type="checkbox"/> Clicking or popping in the jaw |
| <input type="checkbox"/> Pain or discomfort | <input type="checkbox"/> Head, neck or jaw pain (or injuries) | <input type="checkbox"/> Clenching or grinding of your teeth |
| <input type="checkbox"/> Loose or broken teeth, fillings and crowns | <input type="checkbox"/> Sores or lumps near your throat or mouth | <input type="checkbox"/> 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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Ortho treatments, such as braces or a retainer | <input type="checkbox"/> Dentures or partial dentures | <input type="checkbox"/> 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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Brighter/whiter teeth | <input type="checkbox"/> Straighter teeth | <input type="checkbox"/> Close spaces |
| <input type="checkbox"/> Replace metal fillings | <input type="checkbox"/> Repair chipped teeth | <input type="checkbox"/> 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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Feeling tired or sluggish during day | <input type="checkbox"/> Snoring (or being told you snore) | <input type="checkbox"/> Difficulty breathing while you sleep |
| <input type="checkbox"/> Frequent naps during day | <input type="checkbox"/> Using or ever have used a CPAP | <input type="checkbox"/> 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:

Have you had an allergic or adverse reaction to any medication or substance, including food:

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)

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

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

- | | | | |
|----------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental Aesthetics | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Jewelry | <input type="checkbox"/> Latex | <input type="checkbox"/> Metals | <input type="checkbox"/> Other (please list): |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> 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 'Notice of Privacy Practices'.

I do not wish to receive a copy of the Smile Haven Dental Center '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