PATIENT/INSURANCE/HEALTH HISTORY INFORMATION

Patient Name: _____ ☐ **Single** ☐ **Married** ☐ **Other**

Patient Date of Birth: _____ **Patient Soc. Sec. #:** _____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Phone: _____ **Cell:** _____ **Work:** _____ **Email:** _____

Employer: _____ **Dental Insurance:** _____ **Subscriber Name:** _____

Subscriber Date of Birth: _____ **Subscriber SS/ID #:** _____

Whom may we thank for referring you? _____

How would you like your appointments confirmed? Check all that apply. ☐ Phone ☐ Text ☐ Email ☐ Postcard

Are you required to Pre-Med before a dental appointment? ☐ Yes ☐ No

Any allergies? ☐ Latex ☐Penicillin ☐ Codeine ☐ Acrylic ☐Tetracycline ☐ Aspirin ☐ Metals ☐ Dental Anesthetics ☐ Foods ☐ None Listed
Other: _____

What medications are you currently taking? _____
_____

Have you ever taken: Bisphosphonates ☐ Yes ☐ No **Phen-fen/Redux** ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions, surgeries or procedures?

☐ Alcohol/Drug Abuse	☐ Congenital Heart Defect/Disorder	☐ Heart Disease	☐ Psychiatric Problems
☐ Alzheimer's	☐ Convulsions	☐ Heart Murmur	☐ Recent Blood Transfusion
☐ Anemia	☐ Diabetes/Hypoglycemia	☐ Hemophilia	☐ Recent Weight Loss
☐ Angina/Chest Pains	☐ Dialysis	☐ Hepatitis A, B or C	☐ Respiratory Problems
☐ Arthritis/Gout/Rheumatism	☐ Emphysema/Lung Disease	☐ Herpes	☐ Rheumatic Fever
☐ Artificial Valves/Bones/Joints	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Pacemaker
☐ Asthma	☐ Excessive Thirst/Dry Mouth	☐ HIV+/AIDS/ARC	☐ Sinus Problems/Hay Fever
☐ Back Problems	☐ Fainting/Seizures/Epilepsy	☐ Jaw Problems TMJ/TMD	☐ Stomach/Intestinal Problems
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Thyroid Problems
☐ Chemotherapy/Radiation Treatment	☐ Frequent/Severe Headaches	☐ Leukemia	☐ Tuberculosis TB
☐ Cancer/Tumors	☐ Frequent Neck Pain	☐ Liver Problems	☐ Venereal Disease
☐ Cold Sores/Fever Blisters	☐ Heart Attack/Stroke	☐ Mitral Valve Prolapse	☐ NONE OF THE ABOVE

Doctor's Notes: _____
_____

Do you use tobacco? ☐ Yes ☐ No **If so, how used?** _____ **How much?** _____ **How long?** _____

Please rate your general health from 1-10: _____ **Do you wear contact lenses?** ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No How many children have you had? _____
Are you pregnant? ☐ Yes ☐ No If yes, how far along? _____ Are you nursing? ☐ Yes ☐ No

Check all that interest you… ☐ Teeth Whitening ☐ Braces ☐ Invisalign ☐ Extensive Oral Cancer Screening
☐ Sleep Apnea/Snoring Device ☐ Other: _____

*We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interested charges and any other expenses incurred in collecting your account.
* I authorize the staff to perform and necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
* I understand the above information and guarantee this form was completed and update correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Comments/Updates: _____
_____

Signature of Patient/Guardian	**Date**	**Signature of Patient/Guardian**	**Date**
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

PRIVACY PRACTICES, APPOINTMENTS & FINANCIAL INFORMATION

Patient's Name: _____ Date of Birth: _____

We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.

APPOINTMENTS

- We understand that a missed appointment can happen, but we greatly appreciate consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. This allows us the opportunity to offer that appointment to another patient who needs to see the doctor. If you fail to give at least a 24-hour notice of cancellation on multiple occasions, depending on your insurance company's policies, you will be charged a No Call No Show fee or we will not be able to schedule you for future appointments.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.

FINANCIAL

- Our policy requires payment (or estimated payment if you have insurance) in full, for all services rendered, at the time of visit, unless other arrangements have been made with our business manager.
- For your convenience, we accept: Visa, MasterCard, Discover and American Express, in addition to cash, personal check and Care Credit.
- If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account balance.

INSURANCE

- I authorize this *My Smile dental office* to release any information required to process insurance claims.
- Dental Insurance is a contract between you and your insurance carrier, not between the insurance carrier and this office. Insurance companies can take up to 90 days for claims to be paid. It is the responsibility of the patient/guardian to be aware of their plan limitations and waiting periods.
- We assume no responsibility for what your insurance carrier will or will not pay. Please understand that there are many different benefit packages offered by numerous insurance companies and we cannot possibly know the details of each one. We will provide you with an '*estimated* co-payment' amount at the time services are rendered, however any remaining balance after your insurance company has paid, will be the responsibility of the patient/guardian.
- Our office is committed to providing the best treatment for you, regardless of insurance coverage. Our treatment and fees remain the same whether a patient has insurance or not and we want to be flexible in these changing times and will do our best to make this work for everyone.

I understand the above information and guarantee this form was completed and update correctly to the best of my knowledge and understand that it is my responsibility to inform this *My Smile dental office* of any changes to the information I have provided.

~HIPAA ACKNOWLEDGMENT~

☐ **I have received or declined a copy of the Notice of Privacy Practices for this My Smile dental office.**

☐ **I have read and agree with the policies stated below for this My Smile dental office.**

Patient/Guardian Signature: _____ Today's Date: _____

~FOR OFFICE USE ONLY~

We attempted to obtain written acknowledgment but could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining the acknowledgement
□ Other – Please specify below
□ An emergency situation prevented us from obtaining acknowledgement

COVID-19 Pandemic Dental Treatment Consent Form

Patient's Name: _____ **Date of Birth:** _____

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms but still may be highly contagious. Given the current limits of COVID-19 virus testing, it is impossible to determine who is infected with COVID-19 and who is not. Some dental procedures create aerosols which is how the disease can be transmitted. The ultra-fine nature of aerosol spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the scheduling frequency of appointments of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I / my child have an elevated risk of contracting the virus simply by being in a dental office. _____ **(initial)**

- I confirm that I / my child are NOT presenting any of the following symptoms of COVID-19 that are listed below:
  - Fever
  - Shortness of Breath
  - Dry Cough
  - Runny Nose
  - Sore Throat

  _____ **(initial)**

- I verify that I / my child have NOT traveled inside or outside of the United States in the past 14 days to areas that have been grossly affected by COVID-19. _____ **(initial)**

- ***I verify that I / my child have NOT been exposed to any active COVID-19 patients or anyone with active COVID-19 symptoms (mild or severe) within the past 14 days.*** _____ **(initial)**

I am knowingly and willingly consenting to these procedures for myself / my child with the full understanding and disclosure of such risks and alternatives associated with the COVID-19 pandemic, and all of my questions were answered to my satisfaction.

Patient or Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

Patient or Guardian Signature	Date Updated	Patient or Guardian Signature	Date Updated
01)		08)	
02)		09)	
03)		10)	
04)		11)	
05)		12)	
06)		13)	
07)		14)	

Please save and/or print these completed forms. If a printer is available, print and bring the forms with you to your appointment. If a printer is not available, email the saved file to mysmileversailles@gmail.com - thank you!