Confidential Patient Information

Please Print

NAME	*LAST*	*FIRST*	*MIDDLE*	*DOB*	*SEX*	*SS NO.*
ADDRESS	*STREET*		*CITY*	*STATE*	*ZIP*	*PREFERRED PHONE*
CHECK BOX IF UNDER AGE 18 ☐		*PATIENT'S/GUARDIAN'S EMPLOYER*			*OCCUPATION*	
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)						
NAME		*RELATIONSHIP*		*PHONE*		
HOW DID YOU HEAR ABOUT US?			*EMAIL ADDRESS*			

Cancellation Policy

We will confirm your appointment 1 week prior and 24-48 hours prior to your scheduled appointment time. We will confirm via telephone. We ask that you give us a return call so we know that you are confirmed. (Please make sure we have your updated numbers on file). If you have a cleaning appointment, we may also send a postcard, email or text prior to your appointment.

Please give at least 24-48 hours notice if you need to change your appointment time.

This gives us the chance to schedule another patient in your place. We will charge a $40 per hour fee for patients who do not show up for their scheduled appointments and for patients who fail to give us 24 hours notice of rescheduling. Our phones are answered every day except Sunday.

Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice.

We hope you understand that our time is valuable and that we do our best to accommodate your time as well. We always strive to give the best service and appreciate your understanding in this matter.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

INFORMED CONSENT FOR EXAMINATION & DIAGNOSIS

Procedures:
As part of your complete examination, we will look at and feel many structures of your head, neck, mouth, and teeth in order to evaluate their condition.

We will measure the gums next to your teeth to screen for the presence of gingivitis or periodontitis, gum diseases that can lead to tooth loss. This may cause minor discomfort.

We will take X-rays in order to show us conditions that are not visible by looking or feeling. Recent original films of acceptable quality may substitute only if you can bring them with you. We may need to take extra x-rays to capture necessary structures for accurate diagnosis. We may ask you to have a panoramic x-ray taken, which reveals more surrounding structures of the head and neck.

We will use modern digital X-ray processes that can reduce your radiation exposure by up to 90%
Depending on our other findings in these initial examinations, we may also require models or photographs to give us complete information. The models may be mounted on a jaw simulator to reproduce the chewing motion of your jaw.

You will be asked to visit us on a regular basis for continuing care.

Benefits, alternatives, and common risks:
Only with complete information can we develop an accurate diagnosis. There is no effective alternative to these diagnostic procedures. There are no substantial risks from these procedures, although minor discomfort may be experienced by some. Risks associated with X-rays are always concern, but modern equipment ensures a negligible exposure. If you think you may be pregnant, please tell us before any x-rays are made.

Consequences of not performing these procedures:
Failure to allow adequate diagnosis may cause future pain, greater expense for later treatment, loss of teeth, and medical risk.

Every reasonable effort will be made to ensure that your diagnosis is completed properly, although it is not possible to guarantee perfect results. *By signing below, you acknowledge that you have received adequate information about the proposed diagnostic procedures, that you understand this information, and that all of your questions have been answered fully.* You also give permission for information gained from your examination, including photos, x-rays, and any other relevant information to be used in clinical and economic research, practice marketing, and patient education activities and materials, provided that your identity is not reasonably discernible.

_____ I give my consent for the proposed diagnostic procedures as described above.

_____ I refuse to give my consent for the proposed diagnostic procedures as described above. I have been informed of the potential consequences of my decision to refuse complete diagnosis.

_____ _____
Patient's signature / Date Staff signature / Date

_____
Print name

Medical Information & History

Patient Name:_____Age_____

Personal Physician: _____Most recent physical exam date: ____/____/_____

Pharmacy/Location: _____Pharmacy phone number: _____

CIRCLE YES OR NO:

Heart Problems	Yes	No
Cardiac Stent	Yes	No
History of Infective Endocarditis	Yes	No
Heart valve replacement or repair	Yes	No
Pacemaker	Yes	No
High or Low blood pressure (circle)	Yes	No
History of stroke	Yes	No
Taking blood thinners or aspirin	Yes	No
Prolonged bleeding due to slight cut	Yes	No
Anemia or blood disorder	Yes	No
Emphysema or sarcoidosis	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Breathing problems	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Thyroid disease	Yes	No
Diabetes (HbA1c=_____)	Yes	No
Gastric Reflux, IBS, or Ulcer	Yes	No
Epilepsy, convulsions, or seizures	Yes	No
Cold sores or canker sores	Yes	No
Hepatitis (type_____)	Yes	No
HIV	Yes	No
Tumor or abnormal growth	Yes	No
Radiation therapy	Yes	No
Chemotherapy	Yes	No
Mental or psychiatric treatment	Yes	No
Antidepressant medication	Yes	No
Alcohol or drug dependency	Yes	No
Tobacco smoker	Yes	No
E-Cig or vaping device use	Yes	No
Smokeless tobacco	Yes	No
Alcohol or drug dependency	Yes	No
FEMALE – birth control medication	Yes	No
FEMALE – pregnant	Yes	No

ALLERGIC TO:

- ◯ Aspirin, Ibuprofen, Acetaminophen
- ◯ Codeine
- ◯ Penicillin
- ◯ Sulfa
- ◯ Local Anesthetic
- ◯ Latex
- ◯ Other _____
- ◯ No Known Allergies

Describe any medical conditions, treatments, or surgeries that may affect dental treatment:

_____
_____
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List all medications and supplements: (Ask for additional sheet if needed-- or provide list from physician or pharmacy)

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Patient Signature_____ Date_____/_____/_____

Doctor Signature_____ Date_____/_____/_____

Dental History & Information

Patient Name:_____

Previous Dentist: _____**Location:**_____

When was your last dental exam? _____

What is your immediate dental concern? _____

_____

Are you in pain? _____**If yes, for how long?** _____

Type of pain? ……***Throbbing Aching Sharp Dull Severe***

Location:……***UPPER LOWER RIGHT LEFT***

Do you have any swelling or a bump?.....***YES NO***

How fearful are you of dental treatment?.....***VERY SOME SLIGHTLY NONE***

Please describe any problems you have had with the following:

Jaw:_____

Teeth:_____

Gums:_____

Have you ever been diagnosed or treated for gum disease?.....***YES NO***

Have you ever had braces or orthodontics before?.....***YES NO***

Is there anything about your smile you would like to change?.....***YES NO***

Please tell us how we can make your visit more comfortable:_____

_____

Patient Signature _____**Date**_____/_____/_____

Staff Signature _____**Date**_____/_____/_____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are dedicated to serving your dental needs with the best professional advice, care and service available. Please understand that payment of your dental bill is considered a part of your treatment. Please read the following information, and if you have any questions, please ask.

Private Pay
Full payment is due at time of service. We accept cash, personal check, Visa, Mastercard, Discover, and American Express.

Payment Plans
If you would like to make payments, we are happy to offer CareCredit as our third party creditor. We can help you apply for this service.

Dental Insurance
Co-pays and deductibles are due at time of service. Filing your insurance claims is a service we are glad to provide at no cost to you, but does not relieve you of your responsibility for your bill.
Please provide us with a copy of your current dental benefit card. If you do not have a current card, payment in full may be required before treatment.

It is your responsibility to understand your dental benefit plan. Please understand that we file claims to many different benefit companies, and it is impossible for us to know your individual policy. Please be aware that some or all of the services provided may be subject to additional co-pays or deductibles as determined by your insurance company. You have a right to refuse services if you think they may not be covered or payable by your insurance company. We will not become involved in disputes between you and your insurance company regarding non-covered services, diagnoses, co-pays, or deductibles.

Authorization (please read entire paragraph and sign below)
I certify that I, and/or my dependant(s) have insured coverage with _____ and assign directly to Smile Station all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all treatment rendered regardless if covered by insurance or dental benefits. I authorize the use of my signature on insurance submissions. Smile Station may provide my health information to the above-named insurance company for the purpose of obtaining payment for service and determining benefits payable for related services.

I understand that if I fail to pay the entire balance within 30 days from the date of service, a service charge will be assessed each month. I realize that failure to keep the account current may result in denial of dental services. In the case of default on payment of this account, I agree to pay all collection costs and attorney fees incurred in collection attempts. I understand that I am responsible for all bank charges resulting from returned checks or closed accounts. A processing fee may be charged for returned checks.

_____ _____
Signature of Patient, Parent, Guardian, or Representative Date

_____ _____
Print Name of Patient, Parent, Guardian, or Representative Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

{Signature} {Date}

I understand health information may be used or disclosed by mail, telephone, electronic means, and by fax. I authorize the use or disclosure of my health information for purposes of treatments, payment, or healthcare operation to other health care professionals involved in my care/treatment, insurance, third-party payers, pharmacies and the following relative(s) and/or others:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

Below Is 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)