Smile More Dental
Family and Cosmetic Dentistry

➢ Step 1 - Patient Information

First Name: _____ Last Name: _____ MI: ___ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____Cell #: _____ Email: _____

Social Security #: _____ Drivers Lic #: _____ Sex: ☐Male ☐Female

Employer Name: _____ Employer Phone #: _____

Emergency Contact Name: _____ Emergency Contact #: _____

Preferred Pharmacy Name and Number: _____

➢ Step 2 - Parent or Guardian (if patient is under 18 years old)

Relationship to Patient: _____

First Name: _____ Last Name: _____ MI: ___ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell: _____ Email: _____

Social Security #: _____ Drivers Lic #: _____ Sex: ☐Male ☐Female

Employer Name: _____ Employer Phone #: _____

➢ Step 3 - Insurance Information (Write "None" under Name of Insured if you don't have insurance)

Dental Insurance Information

Name Policy Holder: _____
Relationship to Patient: _____
Policy Holder Date of Birth: _____
Policy Holder Social Security #: _____
Policy Holder Employer Name & Address:
_____
_____
Insurance Company: _____
Group # _____
Policy #: _____
Phone #: _____

Medical Insurance Information

Name Policy Holder: _____
Relationship to Patient: _____
Policy Holder Date of Birth: _____
Policy Holder Social Security #: _____
Policy Holder Employer Name & Address:
_____
_____
Insurance Company: _____
Group # _____
Policy #: _____
Phone #: _____

➢ Step 4 - How did you hear about us?

☐1800Dentist ☐Mailer ☐Google ☐Friend/Family _____ ☐Dental Insurance Company ☐Other_____

➢ Step 5 –PLEASE FLIP THE PAGE AND COMPLETELY FILL OUT YOUR MEDICAL HISTORY

Smile More Dental
Family and Cosmetic Dentistry

Initial Consent & Financial Obligations

Initial each line and sign and date below.

_____1. Treatment Consent

I understand that I may have any or all of the following procedures done today or at a following appointment (as needed): exam, xrays (radiographs), cleaning (prophylaxis), fluoride treatment, local anesthetic, and fillings.

_____2. Allergies & Medical History

I understand the importance of accurately describing all of my past and present medical conditions. I understand that antibiotics, pain medications, latex, and other substances may cause allergic reactions which may cause serious medical conditions. I have informed the dentist and staff of all allergies or medical conditions that I have, including pregnancy.

_____3. Changes to Treatment

Ideal treatment is determined by the dentist at the time of exam and will be presented to the patient. I understand that changes to planned treatment may be needed during treatment due to unforeseen conditions during the exam and treatment planning phase of care.

_____4. Financial Obligation

Ideal treatment is determined by the dentist at the time of exam and will be presented to the patient. I understand that treatment plan breakdowns are only estimates of what the insurance will pay. All services must be paid for in advance before they are rendered. I understand that I am obligated to pay any fees associated with treatment as well as any portion, if any, not paid by the insurance company.

_____5. Cancellation/Rescheduling Policy

I understand that a $50 fee can be assessed for appointments of 1 hour or less in duration that are cancelled or rescheduled with less than a 24 hour notice. I understand that up to a $100 fee will be assessed for appointments of greater than 1 hour in duration that are cancelled or rescheduled with less than a 2 day notice.

_____6. Copies of Records

I understand that time and materials will be used when requesting copies of my records. I understand and agree to a reasonable fee that will be assessed if I request these copies.

BY MY SIGNATURE, I CERTIFY THAT I HAVE RECEIVED AND READ A PRINTED COPY AND UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS

Printed Name: _____ Signature: _____ Date: _____

Smile More Dental
Family and Cosmetic Dentistry

Privacy Policy

This notice describes how HEALTH information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice describes the privacy practices of Smile More Dental ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means the patient.
This Notice applies to health information about you that we create or receive and that identifies you.

Our Use and Disclose of Your Health Information Without Your Written Authorization

- **Treatment:** We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
- **Payment:** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
- **Health Care Operations**: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
- **Appointment Reminders:** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.
- **Treatment Alternatives and Health-Related Benefits and Services:** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
- **Disclosure to Family Members and Friends:** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.
- **Disclosures Required by Law:** We may use or disclose your health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.
- **Public Health Activities:** We may disclose your health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect or Domestic Violence:** We may disclose your health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.
- **Health Oversight Activities:** We may disclose your health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.
- **Lawsuits and Legal Actions:** We may disclose your health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.
- **Law Enforcement Purposes:** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.
- **Coroners, Medical Examiners and Funeral Directors:** We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.
- **Organ, Eye and Tissue Donation:** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.
- **Research Purposes:** We may use or disclose your health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.
- **Serious Threat to Health or Safety:** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.
- **Specialized Government Functions:** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.
- **Workers' Compensation:** We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.
- **Marketing and Educational:** We may disclose limited and anonymous records for use as marketing material or as educational examples.
- **Your Written Authorization for Any Other Use or Disclosure of Your Health Information:** We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

BY MY SIGNATURE, I CERTIFY THAT I HAVE RECEIVED AND READ A PRINTED COPY AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION. I AGREE AND CONSENT TO THE ABOVE STATEMENTS.

Printed Name: _____ Signature: _____ Date: _____

Release of Patient Information

This form is used when you would like another person to be involved in any part of your care or financial responsibility at Smile More Dental.
Here are a few examples:

- **If a spouse or family member is involved in your insurance policy, billing, or post-operative care.**
- **If a minor is to be accompanied by someone other than their parent or guardian.**
- **If you are a non-minor child but accompanied by your parents or under your parent's insurance.**
- **You are being sedated and the person accompanying you needs to be informed of your treatment and post-operative procedures.**

The persons listed below will have access to any and all information regarding and related to your care at a need to know basis. This includes but is not limited to the below listed information:

Office notes, treatment plans, clinical charts, x-rays, medical documents, discharge or post-op instructions, prescriptions or prescription records, drug information related to such records, billing records, statements, insurance claims, or receipts

The above information shall only be released to the following persons:

NAME	RELATIONSHIP	DOB	PHONE #

I understand that I have the right to terminate this authorization form. I must notify Smile More Dental in writing regarding termination and effective date.

For Minors (under the age of 18):
I, _____, (Parent/Legal Guardian) authorize the above listed person/persons to authorize medical/dental treatment for my child, _____, by this facility.
I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.
I understand that I may terminate this authorization form. I must notify Smile More Dental in writing regarding termination and effective date.

By signing below, I understand and agree to the above statements.

Signed by: _____ **Date:** _____

Relationship: _____ **Witness:** _____

Smile More Dental
Family and Cosmetic Dentistry

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	_____
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____