Patient Registration

Patient Information

Name: _____ Preferred Name: _____

DOB: _____ Sex: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternative Phone: _____

Driver License #: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Primary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

Secondary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company and assign directly to Smilee Dental Group all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named dental facility.

_____ _____

Signature of Patient, Parent, or Guardian) Name of Patient, Parent, or Guardian

_____ _____

Date Relationship to Patient

Patient Acknowledgements and Authorizations

Patient Communications

By providing the number of my land line, cell phone or other wireless device, and my email address now or in the future, I consent and agree that Smilee Dental Group and any of its affiliates may call me, leave me a message, or send me a text, e-mail, or other electronic message for any purpose related to my account and/or treatment. I also agree that Smilee Dental Group and any of its affiliates may include my personal information in communication. Smilee Dental Group will not charge for any communication, but my service provider may. I agree that Smilee Dental Group may monitor and record any telephone calls to assure the quality of its service or for other reasons.

_____ _____

Signature of Patient, Parent, or Guardian Date

Notice of Privacy Practices

I hereby acknowledge that a copy of Smilee Dental Group's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature of Patient, Parent, or Guardian Date

Dental Materials Fact Sheet

I hereby acknowledge that a copy of the Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

_____ _____

Signature of Patient, Parent, or Guardian Date

Patient Authorization

I understand that the information I have given today is correct to the best of my knowledge. I authorize Smilee Dental Group and the dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

_____ _____

Signature of Patient, Parent, or Guardian Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices (HIPAA), but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other (Please specify)

_____

_____

_____

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship**: _____ **Phone Number**: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) Date

General Dentistry Consent Form

Patient Name: _____

1. Exams, X-Rays, and Cleanings with Fluoride: (Initials: _____)

I understand that in order to assess my treatment plan, the doctor will have to conduct a visual exam as well as take any necessary x-rays for proper diagnosis. I also understand that the long-term success of my treatment and status of oral condition depend on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on my teeth that were not present in previous examinations. I give permission to the dentist to make any/all changes and additions as necessary.

2. Drugs and Medications: (Initials: _____)

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as tissue redness and swelling, pain, itching, vomiting, and/or anaphylactic shock. In the case of medications that can cause drowsiness and lack of coordination, I have been advised not to consume any alcohol nor operate vehicles and/or hazardous devices under the influence for at least 24 hours after treatment. If local anesthetics are used, I understand that occasionally I may have prolonged persistent anesthesia, numbness, and/or irritation of the injection sites.

3. Periodontal Loss (Tissue & Bone): (Initials: _____)

I understand that periodontal disease is a condition that causes gum and bone inflammation and/or loss. I understand that it can lead to the loss of my teeth. Alternative treatment plans (gum surgery, replacement, extraction, etc.) will be discussed with me as necessary. I understand that undertaking any dental procedures may have future adverse effects on my periodontal condition.

4. Sealants and Fillings: (Initials: _____)

I understand that care must be exercised in chewing on sealants and fillings especially during the first 24 hours to avoid breakage. I understand that more extensive fillings than originally diagnosed and planned may be required due to additional decay. I understand that significant sensitivity is common after newly placed fillings.

5. Endodontic Treatments (Root Canals): (Initials: _____)

I realize that there are no guarantees that root canal treatments will save my teeth and that complications can occur from treatments. Occasionally, root canal filling materials may extend through the roots. This does not necessarily affect the success of treatments. I understand that occasionally additional surgical procedures (apicoectomy, extraction, etc.) may be necessary following root canal treatments. I understand that teeth may be lost despite all efforts to save them.

6. Crowns and Bridges: (Initials: _____)

I understand that sometimes it is not possible to match the color of artificial teeth exactly with natural teeth. I further understand that temporary crowns and bridges, which may come off easily, need to be worn. Care is required to ensure that they are kept on until permanent crowns and bridges are delivered. I realize that the final opportunity to make changes to the new crowns and bridges (including color, fit, shape, and size) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from teeth preparations.

Excessive delays may allow for teeth movement. This may necessitate remakes of crowns and bridges. I understand there will be additional charges for remakes due to my delaying cementation.

7. Removal of Teeth: (Initials: _____)

Alternatives to removal (root canal therapy, crown and bridge, periodontal surgery, etc.) will be explained to me as necessary. I authorize the dentist to extract teeth as discussed and any others necessary for reasons in paragraph #5. I understand extracting teeth does not always remove all the infection, if present, and further treatment may be necessary. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, paresthesia (loss of feeling in teeth, lips, tongue, and surrounding tissue), and/or fractured jaw that can last for an indefinite period of time. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

8. Dentures [Complete, Partial, and Stay Plates]: (Initials: _____)

I understand that wearing dentures is difficult. Sore spots, altered speech, and difficulty eating are common problems. Immediate dentures (dentures placed immediately after extractions) may be painful. Immediate dentures may require considerable adjustments and several temporary relines. Permanent relines will be needed in the future. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If remakes are required due to my delay of more than 30 days, there will be additional charges.

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction.

I understand that Smilee Dental Group provides dental services without discrimination based on race, religion, color, national origins, sex, sexual orientation, physical or mental disability, age, or marital status and protects the privacy of each patient.

Patient or Guardian: _____ Date: _____