MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

DENTAL HISTORY

Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Patient Information

Patient Name:_____ Date:_____
Last First MI Preferred

Social Security#_____ Birth Date_____ Age_____ Gender:_____ Marital Status:_____

Phone H: _____W: _____C:_____Email:_____

Would you like confirmations via (please circle one) phone call email Text

Address:_____
Street Apartment# City State Zip code

Employer:_____ Occupation_____ Years at Job:_____

In case of Emergency Contact:_____
Name Relationship Home Phone Cell Phone

Who may we thank for referring you to our practice? _____

Spouse or Responsible Party Information

The following is for (Please circle one): patient's spouse patient's guardian

Name: _____ Gender: _____Marital Status: _____

Social Security#: _____ Birth Date:_____ Employer: _____

Phone (Home): _____(Work): _____(Cell):_____Email:_____

Address:_____
Street Apartment# City State Zip code

Insurance Information

Primary dental Insurance:

Insured/Policy Holder:_____Birthdate:_____SS#/ID#_____

Insured Employer:_____ Relationship to Insured:_____

Ins. Company:_____ Ins. Address:_____

City:_____ State:_____ Zip:_____ Ins Phone:_____

Group #:_____

Secondary Dental Insurance:

Insured/Policy Holder:_____Birthdate:_____SS#/ID#_____

Insured Employer:_____ Relationship to Insured:_____

Ins. Company:_____ Ins. Address:_____

City:_____ State:_____ Zip:_____ Ins Phone:_____

Group #:_____

Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistant as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others may request my records. I certify that the above insurance information, if applicable, is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by iSmile Dental, and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimate portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that I am personally responsible for payment of all fees for dental services provided in this office form or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I agree that credit bureau reports may be obtained, where appropriate. I will notify iSmile Dental if there is a change in the family relationship on the account (divorce, separation, adoption).

__X_____

Signature Date Relationship to Patient

Privacy Policy and Information Practices Patient Rights Statement

Use and Disclosure of Health Information Consent Form

Consent: By signing this form, you do consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office Privacy Policy and Information sharing Policy.

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this Consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, and change in employer.

I,_____ _____,
Please Print Name

Have received a copy of the Above named office's Privacy Policy and Information Practices. I have read and understand the above information. I understand that by signing this form I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

X_____ _____
Signature Date

Consenting Patient Information:

Name: _____Date of Birth_____

Address: _____
Street City State Zip

Telephone: _____
Home Work Cell

Minor children also covered by this consent:

Name: _____Date of Birth_____

Name: _____Date of Birth _____

Name:_____ Date of Birth_____

Name:_____ Date of Birth_____

PATIENT PAYMENT POLICY

Patients who are covered under an insurance policy are responsible for anything that their Insurance does not cover. Insurance Estimates are provided as a courtesy. In the event that your insurance carrier pays less than the estimate, you are responsible for the unpaid balance. Estimates we provide are based on the information that your insurance company has provided to us. All payments are due at time of service & all unpaid balances are subject to late charges. Payment for these services can be made by cash, check, and/or credit/debit card. If patients need to make payment arrangements for their portion, they must speak to the office manager prior to the rendering of ANY services.

PAYMENT ARRANGEMENTS

For patient portions exceeding $300 patients may contact CareCredit for 6 months of interest free financing. This service must be applied for PRIOR to services. Please ask our front office for an information booklet if you are interested in this type of financing. For patient portions higher then $600 patients may leave a credit/debit card on file with the business office and a payment plan may be made. If this option is selected a credit/debit card MUST be left on file. Services will automatically be charged to this card one time per month on the agreed upon date for the agreed upon amount. If the credit/debit card is declined a $10 fee will be applied to the patient's account and the patient will be contacted immediately. If for any reason the patient does not make payment within 30 days of the credit/debit card being declined the account will automatically be sent to collections. Patients who have a patient portion of less than $300 may also apply for CareCredit for interest free financing.

RETURNED CHECK POLICY

There will be a $35 charge for all returned checks. Patients are also responsible for any bank charges that may be assessed. Payment for the returned check must be made with cash, money order, or cashiers check.

COLLECTION AGENCY POLICY

Services rendered must be paid within 30 days from the date of service unless financial arrangements are made PRIOR to services. (See above for payment arrangements.) This is regardless of insurance paying their estimated portion. If the account is delinquent for 90 days, a letter will be sent to the patient notifying them of our decision to send the account to collections. The patient will then have 10 days to make payment in full on the delinquent account or it will be sent to collections immediately. If the account goes to collections the patient is responsible for any fees incurred.

FAILED/SHORT-NOTICE CANCELLATION POLICY

iSmile Dental, requires 24-48 hours' notice to either cancel or change an appointment. If proper notice is not given on the first offense, the patient will be provided with a verbal warning. On the third offense the patient may be dismissed from the practice.

I have read and understand the financial policy, and agree to honor the policy.

X_____

Signature Date