**GREAT SMILES DENTAL CARE**
610 Professional Dr., Suite 250 • Gaithersburg, MD 20879
Tel: (301) 963-5555

www.GreatSmilesDentalCare.com
Email: info@GreatSmilesDentalCare.com

Patient ID (office use only): _____
Date: _____

# PATIENT REGISTRATION FORM

**Great Smiles Dental Care takes your oral health very seriously.**
**To help us meet all your healthcare needs, please fill out this form completely in ink.**

## PATIENT INFORMATION

**Name** (First M.I. Last): _____ **SSN**: _____ **DOB**: _____

**Gender**: ☐ Male ☐ Female **Marital Status** (circle one): minor / single / married / other _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Cell Phone**: _____ **Home Phone**: _____

**Email Address**: _____

Employer: _____ Occupation: _____

**Emergency Contact**: _____ **Phone**: _____ **Relation to patient**: _____

To whom may we thank for referring you? _____

## RESPONSIBLE PARTY (If Different from patient)

**Name** (First M.I. Last): _____ **SSN**: _____ **DOB**: _____

**Relation to Patient**: _____ **Cell Phone**: _____ **Home Phone**: _____

**Home Address** (if different from patient's): _____

## MEDICAL HISTORY

***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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please take time and fill out this section to the best of your knowledge. Thank you.***

Do you have general health problems? ☐ Yes ☐ No Please specify: _____

Are you currently under physician's care? ☐ Yes ☐ No If "yes", please explain: _____

Name of physician (if known): _____ Phone: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Are you on a special diet? ..... ☐ Yes ☐ No

Do you use tobacco? ..... ☐ Yes ☐ No If "yes", specify quantity per day _____

Do you use controlled substances? ..... ☐ Yes ☐ No

Are you currently taking any drugs or medications? ☐ Yes ☐ No Please list: _____

_____

**Are you allergic to**: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Acrylic ☐ Metal
☐ Local Anesthetics ☐ Other, please explain _____

If female, are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing ☐ Yes ☐ No
Taking oral contraceptives? ☐ Yes ☐ No

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## MEDICAL HISTORY (CONTINUE)

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

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

## DENTAL HISTORY

Name of Previous Dentist _____ Phone/Address _____

What prompted you to seek dental care at this time? _____

Why did you leave your previous dentist? _____

The date of your last dental visit _____ How often do you brush? _____ How often do you floss? _____

| | Yes / No |
|---|---|
| • Do your gums bleed while brushing or flossing? | ☐ ☐ |
| • Are your teeth sensitive to hot or cold? ..... | ☐ ☐ |
| • Are your teeth sensitive to sweet or sour? ..... | ☐ ☐ |
| • Are your teeth sensitive to biting pressure? ..... | ☐ ☐ |
| • Do you feel pain in any of your teeth? ..... | ☐ ☐ |
| • Does food constantly get stuck between certain teeth in your mouth? ..... | ☐ ☐ |
| • Have you had any head, neck or jaw injuries? | ☐ ☐ |
| • Have you ever experienced any of the following problems in your jaw? | |
| - Clicking ..... | ☐ ☐ |
| - Pain (joint, ear, side of face)..... | ☐ ☐ |
| - Difficulty in opening or closing ..... | ☐ ☐ |
| - Difficulty in chewing ..... | ☐ ☐ |

| | Yes / No |
|---|---|
| • Do you have frequent headaches? ..... | ☐ ☐ |
| • Do you clench or grind your teeth? ..... | ☐ ☐ |
| • Do you bite your lips or cheeks frequently? | ☐ ☐ |
| • Have you ever had any difficult extractions? | ☐ ☐ |
| • Have you ever had any prolonged bleeding following extractions? ..... | ☐ ☐ |
| • Have you had any orthodontic treatment? | ☐ ☐ |
| • Do you wear dentures or partials? ..... | ☐ ☐ |
| • Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ ☐ |
| • Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc | ☐ ☐ |

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## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that it is my responsibility to inform Great Smiles Dental Care of any changes in medical status.

X_____ _____

**Signature** (Patient/Guardian of a minor) **Date**

## PHOTO AND DIGITAL IMAGES CONSENT

Dear Patient:

Occasionally, we take pictures of your teeth, smile or entire face for insurance and educational purposes. We **DO NOT** put your identity under the images.

By signing this form, I agree to give Great Smiles Dental Care, its associates, and dental assistants permission to take and to use free of charge, photos, and digital images of me and of my dental work for educational use, website, and promotion. Again, **your personal identity will not be revealed**. I understand that I may revoke permission to use my photographs / images at any time by contacting Great Smiles Dental Care in writing.

**Patient Name/Guardian of a minor** (First M.I. Last): _____

X_____ _____

**Signature** (Patient/Guardian of a minor) **Date**

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# NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

(Health Insurance & Accountability Act of 1996)

**Great Smiles Dental Care takes your oral health very seriously.**
**To help us meet all your healthcare needs, please fill out this form completely in ink.**

## PATIENT ACKNOWLEDGMENT

**Patient Name/Guardian of a minor** (First M.I. Last): _____

Thank you for taking the time to **review our Notice of Privacy Practice**. If you have any questions, please do not hesitate to let us know. If you do not have any questions, we would appreciate your acknowledgment receipt of our privacy policy by signing and returning this acknowledgment to our office.

X_____ _____

**Signature** (Patient/Guardian of a minor) **Date**

Do you want a copy of our office Privacy Notice? _____No _____Yes

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**HIPAA Privacy Officer Use Only**

We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but the acknowledgment could not be obtained because:

- ☐ The individual refused to sign the acknowledgment.
- ☐ Communications barriers prohibited us from obtaining the acknowledgment.
- ☐ In an emergency situation prevented us from obtaining the acknowledgment.

Other (specify)_____

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# OFFICE POLICY/PATIENT AGREEMENT

Your dental Insurance is a contract between you and your insurance company. Therefore, it is important that you fully understand your benefits as well as restrictions including but not limited to yearly deductibles, maximum coverage, co-payments. You are fully financially responsible for all dental costs if your dental insurance denies or excludes the services.

We will provide you with **THE BEST ESTIMATE COST of your copayment/coinsurance, and it MUST BE PAID AT THE TIME OF THE SERVICES RENDERED.** Any outstanding balances not covered by your insurance will be billed to you later. As a courtesy, our office will submit to your insurance the services rendered at the date of service on your behalf.

**FINANCIAL CHARGES:** All returned checks are subject to a $35 fee. All balances over 30 days are subject to interest in the amount applicable by state law. We reserve the right to apply a $20 re-billing fee and a $25 late charge toward any outstanding balance. _____ (initial)

**PAST DUE ACCOUNTS:** We reserve the right to report your outstanding balance to any credit reporting agency or credit bureau. If your account is turned over to a collection agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees. _____(Initial)

**MISSED APPOINTMENT FEE:** All appointments require **48 hours prior to the scheduled appointment for cancellation or rescheduling to avoid a fee of $50.00 for breaking the appointment**. _____ (Initial)

**TRANSFERRING RECORDS:** You will need to request in writing the release of your records with Great Smiles Dental Care. We may charge for the copies of your dental records. _____ (Initial)

**By signing below, you acknowledge that you understood the office policy, are responsible for the fees incurred and release us from any obligations regarding your insurance limitations.**

**Print Name** (First M.I. Last) _____
(Patient/Guardian of a minor)

X_____ _____
**Signature** (Patient/Guardian of a minor) **Date**