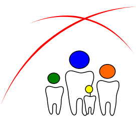
Patient ID (office use only): ____________________
Date: ____________________



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

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

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: ________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________ Ext: ________

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: ______________________ Home Phone: ____________ Cell 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 problem? ☐ 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: ______________________

____

Patient ID (office use only): ____________________
Date: ____

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

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

Yes/No

☐ ☐ AIDS/HIV Positive
☐ ☐ Alzheimer's Disease
☐ ☐ Anemia
☐ ☐ Arthritis / Gout / Rheumatism
☐ ☐ Artificial Heart Valve
☐ ☐ Artificial Joint
☐ ☐ Asthma
☐ ☐ Blood Transfusion
☐ ☐ Cancer
☐ ☐ Chemotherapy / Radiation
☐ ☐ Chest Pains / Angina
☐ ☐ Cold Sores / Fever Blisters
☐ ☐ Congenital Heart Disorder
☐ ☐ Cortisone Medicine
☐ ☐ Diabetes
☐ ☐ Drug Addiction
☐ ☐ Emphysema
☐ ☐ Epilepsy or Seizures

Yes/No

☐ ☐ Excessive Bleeding
☐ ☐ Excessive Thirst
☐ ☐ Fainting Spells / Dizziness
☐ ☐ Frequent Cough
☐ ☐ Frequent Headaches
☐ ☐ Glaucoma
☐ ☐ Hay Fever
☐ ☐ Heart Attack/Failure
☐ ☐ Heart Murmur
☐ ☐ Heart Pace Maker
☐ ☐ Hepatitis A or B or C
☐ ☐ High Cholesterol
☐ ☐ High Blood Pressure
☐ ☐ Hives or Rash
☐ ☐ Irregular Heartbeat
☐ ☐ Kidney Problems
☐ ☐ Leukemia
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure

Yes/No

☐ ☐ Lung Disease
☐ ☐ Mitral Valve Prolapse
☐ ☐ Pain in Jaw Joints
☐ ☐ Psychiatric Care
☐ ☐ Shingles
☐ ☐ Sickle Cell Disease
☐ ☐ Sinus Trouble
☐ ☐ Spina Bifida
☐ ☐ Stomach / Intestinal Disease
☐ ☐ Stroke
☐ ☐ Swelling of Limbs
☐ ☐ Thyroid Disease
☐ ☐ Tonsillitis
☐ ☐ Tuberculosis
☐ ☐ Tumors or Growths
☐ ☐ Ulcers
☐ ☐ Venereal Disease
☐ ☐ Yellow Jaundice

DENTAL HISTORY

Name of Previous Dentist ______________________________ Location & Phone ______________________________

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

Why did you leave your previous dentist? ____

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 you teeth sensitive to biting pressure? .... ☐ ☐
- Do you feel pain to 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

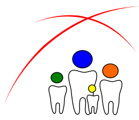
- Do you have frequent headaches? .... ☐ ☐
- Do you clench or grind your teeth? .... ☐ ☐
- Do you bite you lips or cheeks frequently? ☐ ☐
- Have you ever had any difficult extractions? ☐ ☐
- Have you ever had any prolonged bleeding following extractions? .... ☐ ☐
- Have you had any orthodontic treatment? ☐ ☐
- 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 ☐ ☐

Patient ID (office use only): ____________________
Date: ____

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 of patient (or parent/guardian if minor) Date



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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

(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 ACKNOWLEDGEMENT

Patient name (First, M.I., Last): ____

____

Thank you for taking the time to review our Notice of Privacy Practice. If you have any questions, we want to hear from you. If you do not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this acknowledgement to our office at the address indicated above.

______________________________________ ____________________________

Patient/Guardian Signature Date

Please check one: ☐ Please provide me with a copy
☐ I do not require a copy

Great Smiles Dental Care
HIPAA Privacy Officer

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 (specify) ____

____

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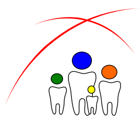

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PHOTO AND DIGTAL IMAGES CONSENT

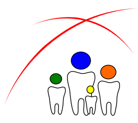
Dear Patient:

Occasionally, we are taking pictures of your teeth, smile or of entire face. We are using them (or just keeping them on file) for Insurance and for Liability reasons. Some of the dental cases are unique and some of them are very helpful for other patients to make a decision regarding dental treatment. We do not sign your name under the images and we use them for internal office purposes only.

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 internal office use, website and for educational purposes. I understand that I may revoke permission to use my photographs / images at anytime by contacting Great Smiles Dental Care in writing.

Name (First, M.I., Last): ____
(Patient/Subscriber or Guardian if a minor)

______________________________________ ____________________
Signature Date



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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 financial responsible for all dental costs if your dental insurance denies or excludes the services.

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

<u>FINANCIAL CHARGES:</u> 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 rebilling fee and a $25 late charge toward any outstanding balance. _________ (initial)

<u>PAST DUE ACCOUNTS</u>: We reserve the right to report your outstanding balance to any credit reporting agency and credit bureau. In the event that 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)

<u>MISSED APPOINTMENT FEE:</u> All appointment requires **<u>2 BUSINESS DAYS</u>** notice for cancellation or rescheduling to avoid a fee of **$50.00 for breaking the appointment**. _______ (Initial)

<u>TRANSFERRING RECORDS:</u> 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/Subscriber or Guardian if a minor)

_______________________________   ___________________________

Signature   Date