- Crab Orchard Dental Center -
Dr. Michael L. Smith, DDS

PATIENT INFORMATION

Please fill out entire form

Today's Date: ____________________

Patient Name: ____ Patient Birthdate: ____________________

First name MI Last name

Gender: Male _____ Female _____ Other _____ Choose not to disclose _____

Patient SSN: ________________________ Driver's License#: _________________________ State: _______

Marital Status: Child _____ Single _____ Married _____ Divorced _____ Widowed _____

Physical Address: ____

Mailing Address: ____

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: _____________________

Email Address: ____

Employer Information:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

IF PATIENT IS A MINOR, PROVIDE PARENT/GUARDIAN INFORMATION:

Guardian Name: ____ Relationship to Patient: _______________

First name MI Last name

Guardian Birthdate: ______________ SSN: _______________ Driver's License: _______________ State: ________

Gender: Male _____ Female _____ Other _____ Choose not to disclose _____

Marital Status: Child _____ Single _____ Married _____ Divorced _____ Widowed _____

Physical Address: ____

Mailing Address: ____

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Home Phone: ____________________ Cell Phone: ____________________ Work Phone: _____________________

Email Address: ____

Employer Information:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

If you will not be responsible for this minor's account, please provide the information of the person responsible:

Name: ___________________________________ Phone Number: ___________________________

Address: ____

EMERGENCY CONTACT INFORMATION:

Name: ____Relatioinship: ________________

Home Phone: ____Cell: _________________________

Name: ____Relationship: ________________

Home Phone: ____Cell: _________________________

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PRIMARY DENTAL INSURANCE

Employee Name: ______________________________ Employee Birthdate: ____________
First name MI Last name

Employee SSN: ______________________ Relationship to Patient:______________

Employer Name: ______________________

Dental Insurance Provider: ______________________________________

ID#: ______________________ Group______________________

Phone Number: ______________________________________

Insurance Address: ______________________________________

SECONDARY DENTAL INSURANCE

Employee Name: ______________________________ Employee Birthdate: ____________
First name MI Last name

Employee SSN: ______________________ Relationship to Patient:______________

Employer Name: ______________________

Dental Insurance Provider: ______________________________________

ID#: ______________________ Group______________________

Phone Number: ______________________________________

Insurance Address: ______________________________________

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PATIENT HEALTH INFORMATION

Patient Name: ______________________________________ Patient Birthdate: ____________________
First name MI Last name

Reason for Dental Visit: ______________________________

Date of last Dental Visit: ______________________________

Are you or have you ever taken AREDIA, BONIVA, ACTONEL, FOSAMAX, ZOMETA: Yes_____ No______

Allergies:
Are you allergic to any of the following (check all that apply):
___ Aspirin ___ Metal ___ Penicillin
___ Latex ___ Sulfa Drugs ___ Local Anesthetics
___ Acrylic ___ Codeine ___ Other: ________________

Women:
Are you pregnant or trying to become pregnant? Yes_____ No______ Due Date___________________
Are you Nursing? Yes_____ No______ Are you taking contraceptives? Yes_____ No______

Blood Thinners:
Are you on a prescribed Blood Thinner? Yes_____ No______
If so, what is the name of your prescribed blood thinner? _________________________
Do you take Aspirin Daily? Yes_____ No______
If so, 81mg _____ or 325mg _____

Substance Use:
If you use any of the following, please circle:
Smoke, e-cigs., chew, snuff or any other form of tobacco? ______________________________
If so, how much? ____

Do you drink alcohol? Yes_____ No______
If so, how many times per week? ________________ How many drinks per sitting? ________________

Do you use illegal substances? Yes_____ No______
If so, what? ____
Date(s) of last use? ____

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Medical Conditions (check all that apply):

__ Acid Reflux
__ ADHD/ADD
__ AIDS/HIV Positive
__ Allergies (seasonal)
__ Anaphylaxis
__ Anemia
__ Angina
__ Anxiety
__ Arthritis/Gout
__ Artificial Heart Valve
When? _____
__ Artificial Joint(s)
Joint? ______
When? ______
Joint? ______
When? ______
__ Asthma
__ Atrial Fibrillation (A-fib)
__ Blood Disease
__ Blood Transfusion
__ Breathing Problems
__ Bruise Easily
__ Cancer
Type? _____
When? _____
__ Chemotherapy
When? _____
__ Chest Pain
__ Cholesterol
__ Cold Sores/Fever Blisters
__ Congenital Heart Disorder
__ Convulsions
__ Cortisone Medication
__ Crohn's Disease
__ Depression

__ Diabetes I or II (please circle)
A1C Level? _____
__ Dry Mouth
__ Emphysema
__ Easily Winded
__ Epilepsy/Seizures
Last episode? _____
__ Excessive Bleeding
__ Excessive Thirst
__ Fainting Spells/Dizziness
__ Frequent Cough
__ Frequent Diarrhea
__ Frequent Headaches
__ Glaucoma
__ Hay Fever
__ Heart Attack/Failure
__ Heart Murmur
__ Heart Pacemaker
__ Heart Trouble/Disease
__ Heart Surgery (Stints/valve replacement bypass)
When? ______
__ Hemophilia
__ Hepatitis A
__ Hepatitis B
__ Hepatitis C
__ Herpes
__ High Blood Pressure
__ Hypoglycemia
__ Hives/Rash
__ Irregular Heartbeat
__ Jaw Pain/TMJ
__ Kidney Disease
__ Leukemia
__ Liver Disease

__ Low Blood Pressure
__ Lung Disease
__ Mitral Valve Prolapse
__ Nerve Conditions:
Fibromyalgia/Trigeminal Neuralgia
__ Osteoporosis
__ Psychiatric Medication/Care
__ Radiation Treatments
For what? ______
When? ______
__ Recent Weight Loss
__ Renal Dialysis
__ Restless Leg Syndrome
__ Rheumatic Fever
__ Scarlet Fever
__ Shingles
__ Sickle Cell Disease
__ Sinus Trouble
__ Sleep Apnea
C-PAP? ______
__ Spina Bifida
__ Stomach Issues
__ Stroke
When? ______
__ Substance Use Disorder
__ Swelling Limbs
__ Thyroid Disease/Hashimoto's Disease
__ Tonsillitis
__ Tuberculosis
__ Tumors/Growths
__ Ulcers
__ Yellow Jaundice

Please list anything that you feel we should know that is not listed above:

____

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PATIENT DENTAL HSITORY

Have you seen a dentist on a regular basis? Yes_____ No______

Have you lost any teeth or have any been removed? Yes_____ No______

Have you ever had major dental surgery? Yes_____ No______
If so, please list, ____

Do you grind your teeth? Yes_____ No______

Does your jaw pop or click? Yes_____ No______

Do you have pain in your jaw or near your ears? Yes_____ No______

Do your gums bleed or hurt? Yes_____ No______

Are any of your teeth sensitive to the following (please circle): hot cold sweets pressure

Are you unhappy with the appearance of your teeth? Yes_____ No______

Have you ever had ortho (braces)? Yes_____ No______

Have you ever had gum surgery (periodontal)? Yes_____ No______

Is there anything about dentistry that you strongly dislike? ____

Have you had any problems or complications with previous dental treatment? ____________________________

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MEDICATIONS

Please list All Medications, even Over The Counter (OTC), that you are taking.

Please give name of the prescription, the milligrams of the pill, and the problem it is meant to treat.

If you have a list with you, we will be more than happy to scan it for you

Name of Prescription	Milligrams	Times you take this medication per day	Reason it is prescribed

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PROVIDER INFORMATION:

Primary Care Physician

Full Name: ______________________________

Phone Number: ______________________________

Address: ______________________________

Date of Last Physical: ______________________________

Specialist:

Full Name: ______________________________

Type of Specialist: ______________________________

Phone Number: ______________________________

Address: ______________________________

Specialist:

Full Name: ______________________________

Type of Specialist: ______________________________

Phone Number: ______________________________

Address: ______________________________

PREFERRED PHARMACY:

Name of Pharmacy: ______________________________

Phone Number: ______________________________

Address: ______________________________

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APPOINTMENT POLICY

If you are unable to keep an appointment, we ask that you kindly give us 24-hour notice.

Late Appointment Policy:
In order to ensure that all of our patients will be seen in a timely manner, it is important that patients present to our office on time for their appointments. Patients who are more than 15 minutes late to a scheduled appointment may be subject to rescheduling.

Broken appointment policy:
We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes as best we can. Please understand that when we make an appointment, we are setting aside enough time to do our best work and that each appointment is for only one patient. We do not overbook our schedule in expectation that some patients will not show for their appointments. Therefore, a broken appointment without adequate notice results in wasted time for us, adding to the cost of providing care for all of our patients.

Confirmation:
We make every attempt to call each patient several times on all phone numbers associated to each account to remind you of your dental appointment. Each appointment has to be confirmed in order to keep the dental appointment. If we do not hear from you to confirm your dental appointment, we will cancel your dental appointment.

If you have confirmed the dental appointment and do not show up for that appointment, we will consider this a Missed Appointment. If you miss 2 confirmed appointments, we will dismiss you as a patient from our practice.

I have read and understand the terms of Dr. Michael L. Smith's appointment policy.

____

Signature Date

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EMERGENCY APPOINTMENTS

We are serious about providing superior dental care. We need you to collaborate with us in that effort. Dr. Smith's policy is to see his patients every six months for a thorough exam and a cleaning with one of our hygienists. That is why we always schedule your next cleaning six months in advance. This is the best way to prevent or catch problems early when they can be easily resolved.

By not routinely getting your teeth examined and cleaned, the result is often serious problems requiring emergency treatment. This causes delays in our very full schedule. Patient's who are diligent with their dental care should not made to wait because of emergencies caused by those who are not committed to proper dental care. Emergencies often result in large fees and sometimes loss of teeth that otherwise might have been saved.

If you have a problem and have not, had a routine exam and cleaning for more than one year, our scheduling coordinator will first schedule for you an appointment for a complete exam including diagnostic x-rays and a cleaning. A treatment plan will be completed and any appointment(s) will be scheduled for treatment. Appointments for the treatment should be scheduled so that you have as few return visits as possible.

We appreciate your cooperation in our goal to help you feel and look your best through excellent dental care!

I acknowledge that I have read and understand Dr. Michael L. Smith's policy to ensure the best possible dental care.

____

Signature Date

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ ______________________________

Please print name of Patient Please sign for Patient / Guardian of Patient

______________________________ ______________________________

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ____________________________________

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?
☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: ________________________ Relationship: _______________ Phone________________

Name: ________________________ Relationship: _______________ Phone________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
The patient refused to sign_____
I could not communicate with the patient_____
Other (please describe): ________________________________
The patient was unable to sign because ____________________

____

Signature of Privacy Officer