

PHAMOUS SMILES

Family Cosmetic & Implant Dentistry

PATIENT INFORMATION (Confidential)

Today's date: _____

Name: _____ Gender: Male Female Other
(FIRST) (M.I.) (LAST)

Preferred Name: _____ Date of Birth: _____ SSN: _____

Marital Status: Single Married Domestic Partner Separated Widowed

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY:

Name of person responsible for this account: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE - PRIMARY

Subscriber Name: _____ Relationship: _____ Phone: _____

Subscriber Employer: _____ DOB: _____ SSN/ID: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group ID: _____

INSURANCE - SECONDARY

Subscriber Name: _____ Relationship: _____ Phone: _____

Subscriber Employer: _____ DOB: _____ SSN/ID: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group ID: _____

Patient/Guardian's Name: _____

Patient/Guardian's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Patient's Acknowledgement of Receipt

The Healthcare Notice of Privacy Practices recognizes that patients have the Right to Privacy concerning their personal health information. Our office makes every effort to protect and preserve patient records in a manner that secures this information.

If you want to authorize someone to have access to your patient records at our office, please provide their names and relationships below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please sign below to confirm that you understand the Privacy Practices of this office.

Patient/Guardian's Name: _____

Patient/Guardian's Signature: _____ Date: _____

INSURANCE GUIDELINES/DISCLAIMERS AND FINANCIAL POLICY

Our goal is to deliver high-quality dental services in a healthy and happy environment at a fair price. We provide our services with honesty and integrity. In return, we expect the same from those we serve.

Patients are responsible for paying the balance in full regardless of the insurance company's determination of benefits or estimated payments. Furthermore, we are legally obligated to collect any copay and deductible as specified by the insurance company. Therefore, we do require payment for the estimated portion and any applicable deductible at the time of service.

As a service to our patients, we submit dental claims to the insurance company on their behalf for payments. However, if the insurance company does not pay the estimated amount for any reason then it becomes the patient's responsibility. Please monitor your insurance payments. For every submitted claim, your insurance company should provide you with an Explanation of Benefit (EOB). If you have questions about the EOB, you may need to contact your insurance company directly.

We sincerely appreciate your business and we strive to provide you with the best overall experience. Your understanding and support of the insurance guidelines/disclaimers and financial policy is essential to our ability to deliver the best possible care.

I understand and agree to the above financial policy regarding payments and insurance obligations.

Patient/Guardian's Name: _____

Patient/Guardian's Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Please answer the following questions. Please mark each Yes/No individually. Please ask if you are uncertain how to respond to a question.

Patient's Name: *First* _____ *Last* _____ Date of Birth _____

1. When was your last dental visit? _____ When were your last dental X-Rays? _____ At what dentist or office? _____
2. When was your last medical exam? _____ Who is your medical doctor? _____
3. How is your health in general? Excellent Good Fair Poor
4. Do you smoke or use tobacco? No Yes If Yes: How many years? _____ How many packs per day? _____
5. Women: Are you currently pregnant or nursing? No Yes

- 6. Medical History:** Have you ever had ...
- | | <u>No</u> | <u>Yes</u> |
|--|--------------------------|--------------------------|
| ➤ Abnormal blood pressure (high or low) | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Allergies (hay fever or environmental) | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Back or Neck Injury..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Blood disorder/anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Abnormal bleeding with surgery or trauma | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Bruising easily | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Cancer/Radiation/Chemotherapy therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Cardiovascular (heart) condition/disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Artificial heart valve..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Congenital heart defects..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Congestive heart failure (CHF) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Heart stents | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pacemaker/defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Fainting spells | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Hepatitis, A, B, C other jaundice or liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ HIV or AIDs | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Hives or skin rash | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Kidney disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Lung trouble (Asthma, Emphysema, COPD, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Persistent or bloody cough..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Prosthetic joint, hip, implant, bone plate or screw | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Stomach ulcer..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Stroke/TIA..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
- Check here if no known medical problems.**

- 9. Medications:** Are you taking ...
- | | <u>No</u> | <u>Yes</u> |
|--|--------------------------|--------------------------|
| ➤ Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Anticoagulants (blood thinners) | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Antihistamines | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Aspirin/Ibuprofen/Aleve | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Bisphosphonates (for treatment of bones, etc.) .. | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Cortisone or other steroids | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Heart drugs, nitroglycerin, digitalis | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Insulin or other diabetes drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Medicine for high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Oral contraceptives | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Tranquilizers (Valium, Xanax, Halcion, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ <i>Other medications (list on Medications form).....</i> | <input type="checkbox"/> | <input type="checkbox"/> |
- Check here if not taking any medications.**

- 10. Allergies:** Have you ever had a reaction to ...
- | | <u>No</u> | <u>Yes</u> |
|---|--------------------------|--------------------------|
| ➤ Aspirin/Ibuprofen | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Codeine or other narcotics | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Latex or rubber products | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Local anesthetics | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Penicillin or Amoxicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Sedatives or tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ <i>Other medications (list on Medications form)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
- Check here if no known allergies.**

11. Have you ever been treated in a Hospital? No Yes

- 7. Dental History:** Do you *currently* have ...
- | | <u>No</u> | <u>Yes</u> |
|---|--------------------------|--------------------------|
| ➤ Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Clenching or grinding teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Teeth sensitive to hot or cold | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ Unpleasant odor or taste in mouth | <input type="checkbox"/> | <input type="checkbox"/> |

12. Please list any other diseases or problems:

8. If you are taking any medications, please list all medications you are taking on the Current Medications form.

I have read the above and have filled out this health history completely, to the best of my ability.

Signature (of Patient or Responsible Party): _____ **Date:** _____

OFFICE USE ONLY

Review Date: _____ **Dentist:** _____ **Review Date:** _____ **Dentist:** _____

MEDICATIONS, PHARMACY PREFERENCE, AND EMERGENCY CONTACT

Patient's Name: *First* _____ *Last* _____ Date of Birth: _____

List ALL medications, including vitamins, herbs, and over-the-counter medications. PLEASE PRINT.

MEDICATION CURRENTLY TAKEN	DOSAGE	DIAGNOSIS (REASON FOR TAKING)

List ALL medication allergies

MEDICATION ALLERGY	REACTION

Preferred Pharmacy

PHARMACY NAME	ADDRESS

Emergency Contact

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE NUMBER

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 release of 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 payors and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

Patient/Guardian's Name: _____ Signature: _____ Date: _____

OFFICE USE ONLY			
Review Date: _____	Dentist: _____	Review Date: _____	Dentist: _____