# PHAMOUS SMILES

Family Cosmetic & Implant Dentistry

## PATIENT INFORMATION (Confidential)

**Today's date: _____**

Name:_____ Gender: ☐ Male ☐ Female
Last First MI

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? _____

**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: _____ 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.

By signing this acknowledgement:

**You are only confirming 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 question individually.
If you are uncertain how to respond to a question, please tell your dentist.

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... | No | Yes |
|---|---|---|
| A. Abnormal blood pressure (high or low) | ☐ | ☐ |
| B. Allergies (hay fever or environmental) | ☐ | ☐ |
| C. Arthritis | ☐ | ☐ |
| D. Back or Neck Injury/Pain | ☐ | ☐ |
| E. Blood disorder, anemia | ☐ | ☐ |
| 1. Abnormal bleeding with surgery or trauma | ☐ | ☐ |
| 2. Bruising easily | ☐ | ☐ |
| F. Cancer / Radiation /Chemotherapy therapy | ☐ | ☐ |
| G. Cardiovascular (heart) disease | ☐ | ☐ |
| 1. Chest pain during/after exertion | ☐ | ☐ |
| 2. Shortness of breath | ☐ | ☐ |
| 3. Swelling of ankles or feet | ☐ | ☐ |
| 4. Cardiac pacemaker/defibrillator | ☐ | ☐ |
| H. Congenital heart lesion/anomaly | ☐ | ☐ |
| I. Artificial heart valve or stent | ☐ | ☐ |
| J. Diabetes | ☐ | ☐ |
| K. Fainting spells | ☐ | ☐ |
| L. Hepatitis, A, B, C other jaundice or liver disease | ☐ | ☐ |
| M. HIV or AIDs | ☐ | ☐ |
| N. Hives or skin rash | ☐ | ☐ |
| O. Kidney trouble | ☐ | ☐ |
| P. Lung trouble, Asthma, Emphysema, Tuberculosis | ☐ | ☐ |
| Q. Persistent or bloody cough | ☐ | ☐ |
| R. Prosthetic (circle): Joint, implant, bone plate or screw | ☐ | ☐ |
| S. Seizures | ☐ | ☐ |
| T. Sinus problems | ☐ | ☐ |
| U. Stomach ulcer | ☐ | ☐ |

| **7. Dental History:** Do you *currently* have... | No | Yes |
|---|---|---|
| A. Bleeding gums | ☐ | ☐ |
| B. Clenching or grinding teeth | ☐ | ☐ |
| C. Teeth sensitive to hot or cold | ☐ | ☐ |
| D. Unpleasant odor or taste in mouth | ☐ | ☐ |

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

| **9. Medications:** Are you taking... | No | Yes |
|---|---|---|
| A. Antibiotics or sulfa drugs | ☐ | ☐ |
| B. Anticoagulants (blood thinners) | ☐ | ☐ |
| C. Antihistamines | ☐ | ☐ |
| D. Aspirin | ☐ | ☐ |
| E. Bisphosphonate (for treatment of bones, etc.) | ☐ | ☐ |
| F. Cortisone or other steroids | ☐ | ☐ |
| G. Heart drugs, nitroglycerin, digitalis | ☐ | ☐ |
| H. Insulin or other diabetes drugs | ☐ | ☐ |
| I. Medicine for high blood pressure | ☐ | ☐ |
| J. Oral contraceptives | ☐ | ☐ |
| K. Tranquilizers | ☐ | ☐ |
| L. *Other medications (list on Medications form)* | ☐ | ☐ |

☐ **Check here if not taking any medications.**

| **10. Allergies:** Have you ever had a reaction to... | No | Yes |
|---|---|---|
| A. Aspirin/Ibuprofen | ☐ | ☐ |
| B. Codeine or other narcotics | ☐ | ☐ |
| C. Iodine | ☐ | ☐ |
| D. Latex or rubber products | ☐ | ☐ |
| E. Local anesthetic | ☐ | ☐ |
| F. Penicillin or Amoxicillin | ☐ | ☐ |
| G. Other Antibiotics | ☐ | ☐ |
| H. Sedatives or tranquilizers | ☐ | ☐ |
| I. Sulfa drugs | ☐ | ☐ |
| J. *Other medications (list on Medications form)* | ☐ | ☐ |

☐ **Check here if no known allergies.**

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

_____

**12. Please list any other diseases or problems:**

_____

☐ **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:** _____ **Provider:** _____ **Review Date:** _____ **Provider:** _____

# CURRENT MEDICATIONS TAKEN BY PATIENT

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

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

| MEDICATION | DOSAGE | DIAGNOSIS / REASON FOR TAKING |
|---|---|---|
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List *ALL* medication allergies

| MEDICATION | REACTION |
|---|---|
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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 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:** _____ **Provider:** _____ **Review Date:** _____ **Provider:** _____