PERFECT SMILES
FAMILY DENTISTRY

Date: _______________

Acct # _______________

CONFIDENTIAL PATIENT INFORMATION

Please Print Clearly

I. Patient Information

Name:______________________________ Birthdate:__________ Gender:__________________
Address:____________________________ City & State:____________ Zip Code:____________
Home Phone: (____)___________ Work Phone: (____)__________ E-mail: __________________
Social Security: ______________________ Driver's License # _____________________
Employer's Name: _____________________ Phone Number: (______)______________

II. Responsible Party (Primary Insurance Information)

Name ______________________________ Relationship to Patient:____________________
Social Security # _____-____-_______ Drivers Lic # ________________ Birthdate:______________
Name of Employer:______________________ Phone #:______________________
Address:_____________________________ City: _________________ Zip Code:______________
Name of Insurance Company:____________________Phone #:_________________
Union/Local:________________________ Group Number:____________________
Occupation:___________________ Date of Hire: ____________________

III. Second Insurance Information (Complete this section if patient is covered by another insurance company)

Name of the Insured :__________________________________ Relationship to Patient:________________
Social Security: ____-____-_______ Drivers Lic #: __________________ Birthdate: ________________
Name of Employer: ________________________________ Phone #: ____________________
Address:_________________________ City & State:____________________ Zip Code: _____________
Name of Insurance Company _______________________________ Phone # (____)______________
Union/Local:_______________________________Group #:_______________________
Occupation: ______________________________ Date of Hire: ___________________

IV. Getting to Know You and Your Family

How did you hear about SmileCare?______________________Last dental x-rays taken?____________________
When was last dental visit? ________________________What treatment was performed?__________________

Please list all immediate family members:

Name:	Relationship:	Birthdate	Date of last dental visit

V. Emergency Contact (Friend or relative not living with you)

Name : ______________________________Telephone: (______)________________

So we may bill your insurance directly, please sign.
I hereby authorize payment directly to SmileCare of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize dental care and the release of any information necessary to bill my insurance carrier. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges and/or attorney fees.

____________________________________ (Signature of the Insured/Responsible Party)

FOR SIX MONTH RECALL ONLY
I hereby confirm there have been no changes to the above information.

Signature of the responsible party_____________________________________ Date____________________

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MEDICAL HISTORY

Patient's Name:________________________ Age:________ Chart #:____________ Office #:____________

1. Is patient in good health? ☐ Yes ☐ No If No, explain ____________________________________
____
2. Physician's Name:________________________________ Phone Number:______________________
Is patient under a physicians care now? ☐ Yes ☐ No If Yes, explain______________________________
____
3. Is patient taking prescribed or any over the counter medication? Birth control medications?........ ☐ Yes ☐ No
If Yes, list medications: ____
4. Is the patient pregnant?________________ If so, how many months? ______________________
5. Has patient taken any weight loss medications? (e.g. PhenFen) .... ☐ Yes ☐ No
6. Has patient ever had a blood transfusion? .... ☐ Yes ☐ No
7. Does the patient smoke? ☐ Yes ☐ No Use tobacco? ☐ Yes ☐ No Use recreational drugs? .... ☐ Yes ☐ No
8. Does the patient use alcohol? ☐ Yes ☐ No If yes, how often? ______________________________
9. Has the patient ever had a allergic reaction to local anesthetic (e.g novacaine)? .... ☐ Yes ☐ No
10. Is the patient allergic to any medication (e.g. penicillin)? .... ☐ Yes ☐ No
11. Has the patient ever had a skin reaction to metals or jewelry? .... ☐ Yes ☐ No
12. Is the patient allergic to latex? .... ☐ Yes ☐ No
13. Has the patient ever had prolonged bleeding after an injury or extraction? .... ☐ Yes ☐ No
14. Does the patient have a cardiac pacemaker or artificial heart valve? .... ☐ Yes ☐ No
15. Is there any family history of diabetes, heart murmur/problems, tumors? .... ☐ Yes ☐ No
16. Does the patient's jaw pop or click when chewing? (TMJ) .... ☐ Yes ☐ No
17. Are you pleased with the appearance of your smile? .... ☐ Yes ☐ No
If no, explain ____
18. What would you like to discuss with the dentist today?

☐ Tooth Ache	☐ Oral Surgery	☐ Partials/Dentures	☐ Cosmetic Dentistry
☐ Gum Problem	☐ Routine check-up	☐ Removal of Wisdom Teeth	☐ Crowns/Bridges
☐ Braces	☐ Second Opinion	☐ Replace missing teeth	☐ Other ____________

19. Does the patient have any missing teeth? ☐ Yes ☐ No If yes, does the patient have an appliance? .... ☐ Yes ☐ No
What type?________________ Year made________________ Is it comfortable?........ ☐ Yes ☐ No
20. Please check each box, yes or no, if the patient has ever had any illness or conditions listed below. Please do not leave it blank.

Y N	Y N	Y N	Y N
☐ ☐ AIDS/HIV	☐ ☐ Allergies	☐ ☐ Anemia	☐ ☐ Angina
☐ ☐ Arthritis	☐ ☐ Artificial Joint	☐ ☐ Asthma	☐ ☐ Bleeding Disorders
☐ ☐ Cancer	☐ ☐ Chemotherapy	☐ ☐ Cold Sores	☐ ☐ Diabetes
☐ ☐ Dizzy Spells	☐ ☐ Emphysema	☐ ☐ Epilepsy	☐ ☐ Emotional Disorder
☐ ☐ Fainting	☐ ☐ Fever Blisters	☐ ☐ Glaucoma	☐ ☐ Heart Attack
☐ ☐ Heart Bypass	☐ ☐ Heart Murmur	☐ ☐ Heart Problems	☐ ☐ Heart Surgeries
☐ ☐ Hepatitis	☐ ☐ High Blood Pressure	☐ ☐ HIV Positive	☐ ☐ Immunosuppressed
☐ ☐ Jaundice	☐ ☐ Kidney Disease	☐ ☐ Liver Problems	☐ ☐ Low Blood Pressure
☐ ☐ Lung Disease	☐ ☐ Nervous/Mental Disorder	☐ ☐ Psychiatric Treatment	☐ ☐ Radiation Therapy
☐ ☐ Rheumatic Fever	☐ ☐ Sinus Trouble	☐ ☐ Stroke	☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis	☐ ☐ Venereal Disease		

21. Has patient had any disease, serious illness/surgery, condition or problem not listed above. ☐ Yes ☐ No If Yes, explain ________
____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

____ ________________________
Patient's Signature/responsible party if patient is a minor Date

For Doctors Use Only

Health History Reviewed By ________________________________(Doctor's Signature) Date____________
Comments:____
____

RECALL REVIEW:
There have been no changes in my health history.

Doctor's Signature ________________ Date ________
Comments ________________________________

Patient's Signature ________________________ Date ____________

PERFECT SMILES
FAMILY DENTISTRY

PATIENT CONSENT FORM

Patient's Name: ____

Address: ______________________________ City ______________________________

CA, Zip ____________________ Phone (   ) ______________ FAX (   ) __________

Privacy Officer (PO) : __________________ Office Contact Person (OCP): ________________

- Posted in our lobby is our *Notice of Privacy Practices*. It provides information about how our office may use and disclose your Protected Health Information (PHI);

You have the right to review our *Notice of Privacy Practices* before signing this *Patient Consent Form*. Please take the time to do so now. A copy is attached.

You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Dental Office Operations. *Request for Restriction of PHI* must be submitted to the OCP in writing and signed by you as specified in our *Notice;*

- Our office does not have to agree with your *Request for Restriction of PHI*. If we agree to your *Request for Restriction of PHI,* we shall honor that agreement.

You have the right to revoke this *Patient Consent Form*. *Revocation of Consent* must be submitted to the OCP in writing and signed by you as specified in our *Notice;*

- *A Revocation of Consent,* does not affect disclosures made prior to the date the *Revocation was made.*
- Our *Notice of Privacy Practices* may change from time-to-time. If it does, you will receive a "revised" Notice on the first visit after changes to the *Notice* were made.
- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during Treatment, Billing/Payment, and Dental Office Operations as outlined in our *Notice*.
- Our office may condition dental treatment upon execution of this *Patient Consent Form*.
- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Patient Consent was signed by: ______________________ ______________________
(Print Name of Patient or Representative) (Relationship to Patient)

______________________________________ ____/____/____
Patient's Signature **Date**

Witnessed by: ______________________________ ______________________
(Print Name of Privacy Officer or Office Contact Person) **(Title)**

______________________________________ ____/____/____
Signature **Date**

White to Patient Chart Canary to Patient

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