

SMILE QUEST DENTAL REGISTRATION FORM

(Please type or print.)

PATIENT INFORMATION

| | | | | |
|-----------------|---------------------|-----------|--|------------|
| Last: | First: | M.I.: | Status: Single <input type="checkbox"/> Mar <input type="checkbox"/> | Soc Sec #: |
| E-Mail: | Driver's License #: | Birthday: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Street address: | Apt #: | City: | State: | ZIP Code: |
| Home Phone #: | Work Phone #: | Ext: | Cell Phone #: | |

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? (Please specify):

HEALTH INFORMATION

| | |
|----------------------------|------------------------|
| Date of Last Dental Visit: | Reason for this visit: |
|----------------------------|------------------------|

Have you ever had any of the following? Please *check* "Yes" or "No" below:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Mental Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Growths | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Head Injuries | | | Due Date: | <input type="checkbox"/> | <input type="checkbox"/> | Codeine Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problem | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Deficiency |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | OTHER Allergies: | | |
| | | TYPE: <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | SULFA Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | STD's | <input type="checkbox"/> | <input type="checkbox"/> | LATEX Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | | | TYPE: | <input type="checkbox"/> | <input type="checkbox"/> | PHEN PHEN Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems | <input type="checkbox"/> | <input type="checkbox"/> | Other: |

| | |
|--|---|
| Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No | Please list medications you are taking: _____ _____ |
|--|---|

| | |
|---|-------------------------|
| Have you been admitted to a hospital or needed emergency care during the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: |
|---|-------------------------|

| | |
|---|-------------------------|
| Are you now under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: |
|---|-------------------------|

| | |
|------------|----------------------|
| Physician: | Physician's Phone #: |
|------------|----------------------|

| | |
|---|-------------------------|
| Do you have any health problems that need further clarification? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: |
|---|-------------------------|

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

| | |
|--|-------|
| Signature of patient, parent, or guardian: | Date: |
|--|-------|

OFFICE USE ONLY, BELOW THIS LINE

| | |
|---|---|
| Doctor Comments: _____ _____ _____ | Doctor Signature: _____ Date: ____ / ____ / ____ |
|---|---|

SPOUSE OR RESPONSIBLE PARTY INFORMATION

| | | | | |
|---|-----------|---|-----------------------|---------------|
| The following is for: <input type="checkbox"/> the patient's spouse <input type="checkbox"/> the person responsible for payment | | | Social Security #: | |
| Name: | | Relation: Patient <input type="checkbox"/> Married to <input type="checkbox"/> Child of <input type="checkbox"/> Other <input type="checkbox"/> | | |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Birthday: | Home Phone #: | Work Phone #: ext. | Cell Phone #: |
| Address: | | | | |
| Street | Apt# | City | State | ZIP Code |

EMPLOYMENT INFORMATION

| | | | | |
|-----------|-------------|-------------------|----------|--|
| Employer: | Occupation: | Employer Phone #: | ext. | |
| Address: | | | | |
| Street | City | State | ZIP Code | |

INSURANCE INFORMATION

| | | | | |
|------------------------------------|-------------------------------|---------------------------------|---|---------------------------------|
| Primary Insurance Company: | | | | |
| Name of Insured: | | Birthday: | Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ID #: | Group #: | | Home Phone #: | |
| Insured's Address (if different): | | | | |
| Street | City | State | ZIP Code | |
| Insured's Employer Name: | | | | |
| Employer's Address (if different): | | | | |
| Street | City | State | ZIP Code | |
| Patient's Relationship to Insured: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other: |
| Secondary Insurance Company: | | | | |
| Name of Insured: | | Birthday: | Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ID #: | Group #: | | Home Phone #: | |
| Insured's Address (if different): | | | | |
| Street | City | State | ZIP Code | |
| Insured's Employer Name: | | | | |
| Employer's Address (if different): | | | | |
| Street | City | State | ZIP Code | |
| Patient's Relationship to Insured: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other: |

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

We record all procedures for security and training purposes _____ Initial

I have read the above conditions of treatment and payment and agree to their content.

| | | |
|---|------|-------------------------|
| Signature of Patient, Parent, or Guardian | Date | Relationship to Patient |
| Signature of Guarantor of Payment/Responsible Party | Date | Relationship to Patient |

DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS



7. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT



11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
12. Do you / would you have any problems chewing gum? _____ YES NO
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ YES NO
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
15. Are your teeth crowding or developing spaces? _____ YES NO
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ YES NO
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
18. Do you dench your teeth in the daytime or make them sore? _____ YES NO
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
20. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE



21. Have you had any cavities within the past 3 years? _____ YES NO
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
25. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
27. Do you frequently get food caught between any teeth? _____ YES NO

GUM AND BONE



28. Do your gums bleed or are they painful when brushing or flossing? _____ YES NO
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
31. Is there anyone with a history of periodontal disease in your family? _____ YES NO
32. Have you ever experienced gum recession? _____ YES NO
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
34. Have you experienced a burning sensation in your mouth? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Patient Consent Form: Use and Disclosure of Health Information Protected Under HIPPA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent disclosures have been made in reliance upon my prior consent.

I hereby consent that photographs may be taken during my treatment to be used in a manner for medical programs developed on behalf of Smile Quest Dental I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond documentation for my chart.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Initial _____

I have been given the Dental Materials Fact Sheet as required by law dated May 2004.

Initial _____

I give my permission to Smile Quest Dental to release information regarding my appointments or account information to _____.

Initial _____

Patient Name: _____ Date: _____

Patient Signature or Legal guardian: _____

Smile Quest Dental Appointment Cancellation Agreement

We request two-business day advance notice for any change or cancellation of your appointment. This allows us the time we reserve especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however, understand that illness and other emergencies occur and we do make exceptions for those rare instances.

A fee will be charged to your account for not honoring this agreement. For an appointment scheduled with our hygienists, the fee is \$55.00. *If your appointment is for laser surgery or any periodontal procedure scheduled longer than one hour, a fee of \$100 will apply.* Appointments scheduled with the doctor will be charged a fee of \$100.00.

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment.

Thank you so much for putting your faith and trust in Smile Quest Dental.

Patients Signature

Date