SMILE QUEST DENTAL REGISTRATION FORM

(Please type or print.)

PATIENT INFORMATION

Last: First: M.I.:			Status: Single ☐ Mar ☐	Soc Sec # :
E-Mail:	Driver's License # :		Birthday:	Gender: ☐ M ☐ 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	
☐	☐	AIDS	☐	☐	Fainting	☐	☐	Mental Disorders	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Nervous Disorders	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Growths	☐	☐	Pacemaker	☐	☐	Tumors
☐	☐	Artificial Joints	☐	☐	Hay Fever	☐	☐	Pregnancy	☐	☐	Ulcers
☐	☐	Asthma	☐	☐	Head Injuries			Due Date:	☐	☐	Codeine Allergy
☐	☐	Blood Disease	☐	☐	Heart Disease	☐	☐	Radiation Treatment	☐	☐	Penicillin Allergy
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Respiratory Problem	☐	☐	Thyroid Deficiency
☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Rheumatic Fever			OTHER Allergies:
		TYPE: ☐ 1 ☐ 2	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	SULFA Allergy
☐	☐	Dizziness	☐	☐	Jaundice	☐	☐	STD's	☐	☐	LATEX Allergy
☐	☐	Epilepsy	☐	☐	Kidney Disease			TYPE:	☐	☐	PHEN PHEN Allergy
☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Stomach Problems	☐	☐	Other:

Do you smoke? ☐ Yes ☐ No	Please list medications you are taking: _____ _____
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No	If yes, please explain:
Are you now under the care of a physician? ☐ Yes ☐ No	If yes, please explain:

	Physician:	Physician's Phone # :

Do you have any health problems that need further clarification? ☐ Yes ☐ 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: ☐ the patient's spouse ☐ the person responsible for payment			Social Security # :	
Name:			Relation: Patient ☐ Married to ☐ Child of ☐ Other ☐	
Gender: ☐ M ☐ 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? ☐ Yes ☐ 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: ☐ Self	☐ Spouse	☐ Child	☐ Other:

Secondary Insurance Company:			
Name of Insured:	Birthday:	Is this person a patient here? ☐ Yes ☐ 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: ☐ Self	☐ Spouse	☐ Child	☐ 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:

PERSONAL HISTORY

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

SMILE CHARACTERISTICS

7.	Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8.	Have you ever whitened (bleached) your teeth? _____	☐	☐
9.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
10	Have you been disappointed with the appearance of previous dental work? _____	☐	☐

BITE AND JAW JOINT

11.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
12.	Do you / would you have any problems chewing gum? _____	☐	☐
13.	Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____	☐	☐
14.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
15.	Are your teeth crowding or developing spaces? _____	☐	☐
16.	Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
17.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
18.	Do you clench your teeth in the daytime or make them sore? _____	☐	☐
19.	Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
20.	Do you wear or have you ever worn a bite appliance? _____	☐	☐

TOOTH STRUCTURE

21.	Have you had any cavities within the past 3 years? _____	☐	☐
22.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
23.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
24.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
25.	Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
26.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
27.	Do you frequently get food caught between any teeth? _____	☐	☐

GUM AND BONE

28.	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
29.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
30.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
31.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
32.	Have you ever experienced gum recession? _____	☐	☐
33.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
34.	Have you experienced a burning sensation in your mouth? _____	☐	☐

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