Name __________________________

**Patient Information**

What is the reason for today’s visit? ____________________________________________

How did you hear about our office? (person’s name if any) __________________________

Is there anything about your smile that you do not like? ___________________________

How long since your last visit to the Dentist? _____________________________________

Why did you leave your last dentist? _____________________________________________

How long would you like to keep your teeth? _____________________________________

Are you interested in knowing the options available for a more beautiful smile? Y or N

How would you rate the appearance of your teeth? (Poor) 1 2 3 4 5 6 7 8 9 10 (great)

Are all of your teeth in alignment (straight)? Yes or No ___________________________

Do you have any missing teeth? Yes or No ___________________________

Is your bite comfortable when chewing, biting? Yes or No _________________________

Are any Broken/ chipped? Y or N _______________________________________________

Do you have frequent headaches? Yes or No _______________________________________

Do you have any old metal fillings or dental treatment that you are unhappy with? Y or N

What would you like to change the most about the appearance of your teeth?

________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Favorite foods? _____________________________________________________________

Favorite Music? _____________________________________________________________

Active in Hobby or Sports? ____________________________________________________

Please give us your Facebook ID for special online promotions _______________________

What expectations do you have of this Dental Office as your oral healthcare provider?

________________________________________________________

___________________________________________________________________________
Welcome to our Dental Office!

We warmly welcome you to our office. Please take a few moments to read the following information so we can better serve you. It is our goal to help you reach and maintain maximum oral health.

**Standard of Care**

We are true believers that preventative care and patient education are the keys to optimal dental health. We strive to provide “dental health care” vs. “disease care”. That’s why we focus on thorough exams – checking the overall health of your teeth and gums, performing oral cancer exams, and taking x-rays per standard of care. We also know that routine cleanings, flossing, sealants, and fluoride are all helpful in preventing dental disease. Not only are we focused on the beauty of your smile, but we are also concerned about your dental health. A review of your medical history, updated once a year, can help us stay informed of your overall health, any new medications, and any illnesses that may impact your dental health.

**A note for our patients with dental insurance:**

We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance company. We will do our best to make as close of a calculation as possible of what your insurance plan will cover however regardless of what your insurance plan pays for you, you are responsible for all fees.

**Payment Arrangements:**

Payment is due when treatment is rendered. We do offer financing through Chase and Care Credit, some with no interest. Please note that a late fee of $10.00 a month will be added to your balance after 60 days. Should your account ever be sent to collections, a 10% collection fee will be added to your balance.

**Appointment Cancellation Policy:**

Please help us deliver the best quality dental care by keeping scheduled visits. We do not double book, your appointment time is reserved just for you! We do our best to run on time and in return ask that you value our time. **If you are unable to keep an appointment we kindly ask that you give us at least 48 working hours notice.** Please call us during working hours if you need to cancel your appointment. We reserve the right to charge $75 per hour for appointments cancelled with less than adequate notice.

I have read and understand the above information:

________________________________                    _________________________
Signature of Patient or Legal Guardian                    Date

_________________________________                  ____________________________
Print Name of Patient or Legal Guardian                  Witness
Patient Photo Consent Form

I, ________________________________, do hereby give my consent to Yanitza McConnell DMD for the use of my dental photos, videos, and/or portrait for the advancement of cosmetic dentistry, educational viewing by other dental professionals, and in the promotion of cosmetic dentistry without my name. I release and forever discharge him from any claims, demands or liabilities on account of such use. Before and after photos may be used to present future case studies to patients, used on our dental web site, as well as in our office slide show.

Thank you for your time and cooperation.

Signature __________________________ Date ______________

I am the parent or guardian of the minor named above and have the legal authority to execute the above releases. I approve the foregoing and waive any rights in the premises.

Parent Signature __________________________ Date ______________
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, the office of Yanitza McConnell, D.M.D. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

Please refer to our office's Notice of Privacy Practice for a more complete description of such uses and disclosures.

With my consent, the office of Yanitza McConnell, D.M.D. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office of Yanitza McConnell, D.M.D. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to the office of Yanitza McConnell, D.M.D. use and disclosure of my PHI to carry out TPO. If I do not sign this consent, the office of Yanitza McConnell, D.M.D. may decline to provide treatment to me.

With my consent, the office of Yanitza McConnell, D.M.D. may disclose my PHI to carry out TPO to the following selected area(s):

<table>
<thead>
<tr>
<th>Dentist/Specialist</th>
<th>Physician</th>
<th>Legal Guardian Power of Attorney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative(s)</td>
<td>Other</td>
<td>______________</td>
</tr>
</tbody>
</table>

__________________________________________  _______________________
Signature of Patient or Legal Guardian       Date

_______________________________                    _______________________
Print Name of Patient or Legal Guardian       Witness
Are you able to identify your bite?

- Crowding [ ]
- Spacing [ ]
- Deep Bite [ ]
- Overjet [ ]
- Crossbite [ ]
- Underbite [ ]
- Open bite [ ]
- Other: __________________

What style of treatment do you prefer to correct this bite?

- Metal braces [ ]
- Invisalign [ ]
- Clear braces [ ]
### PATIENT REGISTRATION

<table>
<thead>
<tr>
<th>ID:</th>
<th>Chart ID:</th>
<th>First Name:</th>
<th>Last Name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Patient Information**

- **Address:**
- **City, State, Zip:**
- **Home Phone:**
- **Work Phone:**
- **Ext:**
- **Cellular:**
- **Birth Date:**
- **Age:**
- **Soc Sec:**
- **Drivers Lic:**
- **Primary Insurance Policy Holder:**
- **Secondary Insurance Policy Holder:**
- **Policy Holder:**
- **Responsible Party (if someone other than the patient):**

**Sex:**
- **Male**
- **Female**

**Marital Status:**
- **Married**
- **Single**
- **Divorced**
- **Separated**
- **Widowed**

**Patient Information**

- **Address:**
- **City:**
- **State / Zip:**
- **Home Phone:**
- **Work Phone:**
- **Ext:**
- **Cellular:**
- **Drivers Lic:**

**Employment Status:**
- **Full Time**
- **Part Time**
- **Retired**

**Student Status:**
- **Full Time**
- **Part Time**

**Medicaid ID:**
- **Pref Dentist:**

**Employer ID:**
- **Pref Pharmacy:**

**Carrier ID:**
- **Pref Hyg:**

**Primary Insurance Information**

- **Name of Insured:**
- **Insured Soc. Sec:**
- **Insured Birth Date:**
- **Employer:**
  - **Address:**
  - **Address 2:**
  - **City, State, Zip:**
- **Rem. Benefits:**
  - **Rem. Deduct:**

**Secondary Insurance Information**

- **Name of Insured:**
  - **Insured Soc. Sec:**
  - **Insured Birth Date:**
  - **Ins. Company:**
    - **Address:**
    - **Address 2:**
    - **City, State, Zip:**
- **Rem. Benefits:**
  - **Rem. Deduct:**

**Emergency #:**
- **I would like to receive correspondence via e-mail:**

**Relationship to Insured:**
- **Self**
- **Spouse**
- **Child**
- **Other**