Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient_____

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Internet ☐ School/Work ☐ Other _____

Name of person or office referring you to our practice: _____

Emergency Contact

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Birth Date:_____Phone (Home): _____ (Work): _____ Ext: _____

Best time to call: _____

Address: _____Cell Phone (optional)_____
Street Apartment #

_____
City State Zip Code E-MAIL ADDRESS

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID# _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other _____

Insurance Plan Name and Address: _____

_____

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. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment.

_____
Patient or Guardian Signature Date

As a condition of your treatment, **financial arrangements must be made in advance**. All emergency dental services, or any dental service performed without previous financial arrangements, must be paid 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. We will help prepare the patient's Insurance forms and submit them electronically. We will accept assignment of benefits and patient's portion is due at the time services are rendered. However, we cannot render services on the assumption that our charges will be paid by an insurance company. **In the event the Insurance Company does not pay us you are responsible for the full amount due.** 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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of
such care to third party payers and/ or other health practitioners. **This signature also acknowledges that I have received a copy of iSmile Dental Associates privacy practices and that I have also been given and understand the financial policy and cancellation policy of iSmile dental Associates.**

Date: _____ Signature of patient or guardian_____

Patient Name (Please Print) _____

HEALTH HISTORY

Patient Name: _____ Birth Date: _____

- Name of Medical Physician: _____ Phone: _____
- Date of last dental visit: _____ Reason for today's visit: _____
- Please list any medications including herbal supplements you are currently taking:

_____

_____

_____

- Please list any medication you've had an allergic or other adverse reaction to: _____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:

_____

- 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 for a particular problem? ☐ Yes ☐ No
  If yes, please explain:

_____

- Are you required to Pre-Medicate before dental treatment? ☐ Yes ☐ No
- Are you taking any medication for the treatment of Osteoporosis? ☐ Yes ☐ No
  If yes, please list medications: _____
- Abnormal blood pressure? ☐ Yes ☐ No
  If yes, what is it usually? S_____/D_____
- Do you consume grapefruit juice, grapefruits or grapefruit extract? ☐ Yes ☐ No
- Do you take antacids? If yes, how often? _____ ☐ Yes ☐ No
- Are you taking tagament (climetidine)? ☐ Yes ☐ No

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

MEDICAL HISTORY

Yes/No
- ☐☐ AIDS/HIV
- ☐☐ Alcohol/ Drug Dependency
- ☐☐ Anemia
- ☐☐ Anxiety/Depression
- ☐☐ Arthritis
- ☐☐ Asthma
- ☐☐ Blood Disease
- ☐☐ Cancer
- ☐☐ Chemotherapy
- ☐☐ Cigarette, Pipe, Cigar Smoking, or Chewing Tobacco?
  How many per day? _____
- ☐☐ Diabetes
- ☐☐ Dizziness/Fainting
- ☐☐ Epilepsy
- ☐☐ Excessive Bleeding
- ☐☐ Glaucoma
- ☐☐ Growths/Tumors
- ☐☐ Hay Fever
- ☐☐ Head Injuries
- ☐☐ Heart Disease
- ☐☐ Herpes
- ☐☐ Heart Murmur/MVP/Congenital Heart Defect.
- ☐☐ Hepatitis/Jaundice
- ☐☐ Hiatal Hernia/Acid Reflux
- ☐☐ High Blood Pressure
- ☐☐ High Cholesterol
- ☐☐ Kidney Disease
- ☐☐ Latex Allergy
- ☐☐ Liver Disease
- ☐☐ Lymph Nodes/Sore/Enlarged
- ☐☐ Mental Health Issues
- ☐☐ Pacemaker
- ☐☐ Previous Biopsies
- ☐☐ Osteoporosis

Yes/No
- ☐☐ Replacement of Joints
- ☐☐ Radiation Treatment
- ☐☐ Respiratory Problems
- ☐☐ Rheumatic Fever
- ☐☐ Rheumatism
- ☐☐ Sinus Problems
- ☐☐ Skin Disease
- ☐☐ Stomach Problems
- ☐☐ Stroke
- ☐☐ Thyroid Problems
- ☐☐ Tuberculosis
- ☐☐ Ulcers
- ☐☐ Venereal Disease

DRUG ALLERGIES
- ☐☐ Codeine, valium or other sedatives
- ☐☐ Penicillin/other antibiotics
- ☐☐ Local Anesthetics
- ☐☐ Other

WOMEN
- ☐☐ Are you nursing?
- ☐☐ Are you taking Birth Control Medication?
- ☐☐ Are you pregnant?

Due Date: _____

DENTAL HISTORY

Yes/No
- ☐☐ Bite/Chew Nails
- ☐☐ Biteguard Therapy
- ☐☐ Bleeding Gums
- ☐☐ Bleaching Treatment
- ☐☐ Blisters/Sores on Lips
- ☐☐ Burning Sensation on Tongue
- ☐☐ Chew on one side of mouth
- ☐☐ Clench/Grind Teeth
- ☐☐ Gums swollen or tender
- ☐☐ Jaw Pain or Tiredness
- ☐☐ Loose teeth or broken fillings
- ☐☐ Orthodontic Treatment
- ☐☐ Pain around ear
- ☐☐ Periodontal Treatment
- ☐☐ Persistent Bad Breath
- ☐☐ Sensitivity to cold, heat, sweets or brushing
- ☐☐ Wisdom teeth removed

How often do you floss? _____

How often do you brush? _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please 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.

_____ _____

Patient or Guardian Signature *Date* *Doctor Signature* *Date*

FINANCIAL POLICY

We appreciate having the opportunity to serve you and will make every effort to ensure you of quality dental care. We also strive to keep the costs to our patients as affordable as possible. In order to achieve these goals, we need your assistance and understanding of the following payment policy.

Based on the information you provide to us, we estimate your insurance co-payment which is due at the time services are rendered. We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.**

If you have dental insurance, we will be glad to file claims as a courtesy to you. Below is our policy on insurance:

- *It is **YOUR** responsibility to ensure that the insurance information we have on file is complete and accurate. We have no way of knowing when/if your insurance coverage changes.*
- *Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not with your insurance company. The filing of insurance claims is a **courtesy** we extend to our patients. All charges are **YOUR** responsibility from the date the services are rendered, whether your insurance company pays or not. Please remember that not all services are a covered benefit.*
- *Your copayment is due at the time of service. Copayments are estimated from the information your insurance company gives us. We an not be responsible for actual payments made by your insurance carrier. After your claim is paid you may owe more money or have a credit that would be refunded to you.*
- *If your insurance company does not pay in full within 45 days, we may require you to pay the balance due.*

In cases of divorced parents, the parent who brings the child to our office will be deemed responsible for payment. Please do not put us in the uncomfortable position between any family disputes.

Any check returned to us by the bank due to insufficient funds will result in a $25.00 service charge to your account.

Sometimes insurance pays less than what we had anticipated. In those instances you, obviously, are responsible for the balances and will receive a bill. Bills are sent from our office on a monthly basis with a statement mailed to your billing address. Please let us know if your billing address changes. Payment is expected within 7 days.

CANCELLATION POLICY

As a courtesy, our office makes every effort to contact our patients to confirm appointments. It is your responsibility to keep all scheduled appointments. We ask for the courtesy of 48 hours notice if you are unable to keep a scheduled appointment. Appointments that are broken with less than 24 hours notice will be charged a broken appointment fee of $50.00. Failure to cancel a scheduled appointment will result in a $50.00 cancellation fee.