



## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please indicate YES by marking the box:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS / HIV<br><input type="checkbox"/> Allergies<br>_____<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Artificial Joints<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Growths<br><input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> Nervous Disorders<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pregnancy<br>Due date: _____<br><input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Snoring<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Codeine Allergy<br><input type="checkbox"/> Penicillin Allergy<br><input type="checkbox"/> Pre-medication<br><br>OTHER:<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ |
|--|--|--|

- Do you have any specific drug allergies?    Yes    No  
    If yes, please list: \_\_\_\_\_
  
- List all of the medications you are currently taking: \_\_\_\_\_
  
- 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?    Yes    No  
    If yes, please explain: \_\_\_\_\_
  
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
  
- Do you have any health problems that need further clarification?    Yes    No  
    If yes, please explain: \_\_\_\_\_

Are you interested in Aesthetic dental work to improve your smile?    Yes    No (If yes, please describe what you feel defines a beautiful and healthy smile)

Are you interested and/or considering dental implants?    Yes    No  
Would you like information about implants and the latest technology?    Yes    No

## Dental History

**Please Circle Yes or No:**

- Do your gums bleed?    Yes    No
  - Are you concerned about your breath?    Yes    No
  - Do you have any sores or lumps in or near your mouth?    Yes    No   If yes, where \_\_\_\_\_
  - Do you have or have you ever had any of the following? (Please mark box)
- |  |  |
|--|--|
| <input type="checkbox"/> Pain in your jaw joints | <input type="checkbox"/> Difficulty in opening or closing your mouth |
| <input type="checkbox"/> Soreness when chewing   | <input type="checkbox"/> Clenching or grinding your teeth            |
| <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Periodontal Treatment                       |



Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

\_\_\_\_\_  
Date: \_\_\_\_\_

Patient Name

### Patient Rights

**Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information.

**Confidential Communications:** You have the right to request that we communicate with you in a certain way. You may request that we only communicate our health information privately with no other family members present or through mailed communications that are sealed.

**Inspect and Copy Your Health Information:** You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your information, please let us know. We will charge you a fee of approximately \$35.00 for copying and assembly.

**Amend Your Health Information:** You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. For standardization purposes, please provide us with a written request of your information.

**Documentation of Health Information:** You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations.

**Request a Paper Copy of this Notice:** You have the right to obtain copy of this Notice of Privacy Practices directly from our office at any time...

**\*On occasion, DC Smiles may use your image for our website and/or photo books. Please let us know if you prefer your image not be used.**

### Dental Benefit Explanation/Financial Policy

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 and 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 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 patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this 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.

### Dental Benefit Explanation/Financial Policy

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

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: \_\_\_\_\_

### Cancellation and No-Show Policy

Office hours are by appointment and we reserve your appointment time for you alone. When you make an appointment, please be sure that you will be able to keep it. Morning appointments are ideal for more complicated procedures. When appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one visit. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes or delays. If you have a dental emergency that needs immediate attention, we will always do our very best to accommodate you. We also expect that other patients who might be slightly inconvenienced will understand the nature of an emergency situation. At some point, they may need the same courtesy too!

Unlike other offices, we call to confirm your appointment 24hrs in advance. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office as soon as possible. There will be a charge of \$125 per 30 minutes of scheduled time for a broken appointment or cancellation with less than 24 hours' notice. For your first treatment planned appointment we will require in advance a percentage deposit of your proposed treatment plan fee in order to secure your personal block of time.

**If you have any questions about our appointment cancellation and no-show policy, please feel free to speak with our office manager.**

I understand the *DC Smiles Cancellation and No-Show* policy:

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date