PATIENT INFORMATION

Please circle one of the following: MALE FEMALE MARRIED SINGLE CHILD

NAME: ______________________________________**BIRTHDATE:** ____________________

ADDRESS: ____**APT#:** ___________________

CITY: ____________________________**STATE:** ____________**ZIP CODE:** _______________

HOME #: _____________________**WORK #:** _________________**CELL#**________________

EMPLOYER: _______________________________________**SS#:** ______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

EMAIL ADDRESS: ____

MEDICAL HISTORY

OFFICE/PHYSICIANS: ____

PHONE #: ____

ARE YOU UNDER A DRS. CARE? ____

REASON: ____

ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? ____________________________

ANY ALLERGIES TO MEDICATIONS OR SUBSTANCES? _______________________________

DO YOU SMOKE? YES, NO ARE YOU PREGNANT? YES, NO NURSING? YES NO

DO YOU NEED TO BE PREMEDICATED FOR DENTAL TREATMENT? YES NO

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV POSITIVE	COUGH	HEART PACEMAKER	PSYCHIATRIC CARE
ANEMIA	COLD SORES	HEART SURGERY	RHEUMATISM
ARTIFICIAL JOINTS	DIABETES	HAY FEVER	RESPRITORY DISEASE
ARTIFICIAL HEART VALVE	DRUG ADDICTIONS	HEPATITIS A	SHORT OF BREATH
ASTHMA	EPILEPSY	HEPATITIS B	SWELLING
ARTHRITIS/GOUT	EXCESSIVE THIRST	HEPATITIS C	SCARLET FEVER
BLOOD DISEASE	EMPHYSEMA	HYPOGLYCEMIA	SINUS TROUBLE
BLOOD TRANSFUSION	FAINTING	HEMOPHILIA	KIDNEY DISEASE
BACK PROBLEMS	FEVER BLISTERS	HERPES	SICKLE CELL ANEMIA
CANCER	GLAUCOMA	JAW PAIN	TUBERCULOSIS
CONGENITAL HEART LESION	HEADACHES	LOW BLOOD PRESSSURE	ULCERS
CHEST PAIN	HEART MURMER	LUNG DISEASE	VENEREAL DISEASE
CHEMO/RADIATION TXS	HEART TROUBLE	LIVER DISEASE	
CORTISONE TREATMENTS	HIGH BLOOD PRESSURE	MPV	

HAVE YOU EVER HAD ANY OTHER HEALTH PROBLEMS NOT LISTED: YES NO

CONSENT: The undersigned herby authorizes to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be needed. I further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embody a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is my responsibility and that payment is due at the time services are rendered. I further understand that finance charges may be added to any account that is 90 days past due. In the event of default, I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an addition 50% of balance added for collection costs as will be required to effect collection of this account.

PATIENT/GUARDIAN SIGNATURE: ____**DATE:** ____________

DENTISTS SIGNATURE: ____

PLEASE ANSWER *ALL* QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Purpose of visit? ____
2. Are you aware of a problem? YES NO
   If yes: are you in pain? ____
3. Previous Dentist: Name____
4. How long has it been since your last dental visit? ______________________________
5. What was done at that time? ____
6. Do you go regularly to your cleaning appointments? YES NO
7. When was the last time your teeth were cleaned? ________________________________
8. Have you lost or had any teeth removed? YES NO
   If yes, why? ____
   Were they replaced? YES NO
   Are you happy with the replacement? YES NO
9. Have you had dental x-rays taken in the last year? YES NO
10. Have you ever had any problems with a dental treatment? YES NO
    If yes, explain____
11. Do you clench or grind your teeth? YES NO
12. Do you have any muscle soreness in your face, jaw or ear? YES NO
13. Do you have frequent aches of the head/neck region? YES NO
14. Does food get caught in your teeth? YES NO
15. Are your teeth sensitive to: HOT COLD SWEETS PRESSURE (circle all that apply)
16. Have you ever had gum surgery in the past? YES NO
17. Have you ever had a "deep cleaning" in the past? YES NO
    If yes, how long ago? ____
18. Do your gums bleed or hurt? YES NO
19. Have you ever been informed about periodontal disease? YES NO
20. How often do you brush your teeth? ____
21. Do you floss? ____________How often? ______________________________________
22. Have any of your teeth become: LOOSE SHIFTED CHIPPED (circle all apply)
23. Are you happy with the appearance of your teeth? YES NO
24. Are you interested in whitening? YES NO
25. Are you interested in straightening your teeth? YES NO
26. Have you had any unpleasant dental experiences in the past? YES NO
    If yes, please
    explain?____
    ____
    ____

I certify that the above information is true and accurate to the best of my knowledge:

Patient/Guardian signature: ____DATE: ___________
Dentist's signature: ____DATE: ___________

Policies

Effective: March 2016

Missed Appointments:
Our team reserves your appointment date and time exclusively for you. We require at least a 24-hour notice if you are unable to keep your appointment and offered an opportunity to reschedule. There is a **$25.00 charge** towards your account for appointments cancelled without notice.

Saturday Appointments:
Patients who cancel their Saturday appointment or reschedule without the required 24 hours' notice will be required to supply us with a credit card to secure their rescheduled appointment. Smile Dental Care will not place any charges on the credit card, so long as the rescheduled appointment is honored or rescheduled within the 24 hours prior to the new appointment day.

Late Appointment Policy:
If you are late to your appointment, in fairness to others, our team will make every attempt to accommodate you by offering to either wait for the next available opening or reschedule your appointment. **Arriving late is defined as arriving 10 minutes after your appointment time.**

Health Insurance Portability and Accountability Act (HIPAA):
Our office complies with HIPAA, which is a federal health safety act to protect individual's health record information. Every patient is required to sign a "Notice of Privacy" form. Without this, the patient cannot be treated by the dentist and dental assistant. Please read and sign our Notice of Privacy form.

Treatments of Minors:
All patients under the age of 18 are required to have a parent or legal guardian present to be seen by the dentist. Without the presence of a parent or legal guardian, the patient's appointment must be rescheduled.

Insurance Policy:
Our office accepts all PPO insurances and the Medical Card for Kids (under the age of 18).
As a courtesy, we will bill your insurance company but cannot be held responsible if your insurance company does not pay or receive claims in a reasonable amount of time.

Our office will go over an **ESTIMATED** cost of your dental services. Our team estimates your co-insurance, based on the information your insurance company provides for us. It is not guaranteed your insurance will cover your dental procedures.

- Please be aware your insurance may require a yearly deductible or co-payment, which you are responsible for as an out-of-pocket expense.
- Please be aware your insurance might not cover particular dental services. You are held accountable for any non-covered dental services as an out-of-pocket expense if you decide to continue with the dental treatment.

If your **insurance terminates,** it is your responsibility to make us aware of any changes. Contact us at 773-788-9090 or by email at: archer@smiledentalcenters.com with updates.

- Any dental services rendered after your insurance's term date, will be an out-of-pocket expense to you. Your terminated insurance will not cover any dental treatments provided after the termination date.

Payments:
Our team strives to provide financial comfort to our patients. We accept the following forms of payments: credit cards, debit cards, checks and cash. We also offer in-house payment plans and financing monthly payment options.

- We require a payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, please contact the office directly.
- Co-payments are due prior to treatment.
- Checks returned from the bank will result in a $25.00 fee.
- You are held accountable for any late fees, expenses, or cost related to the collection of any unpaid balances of your account. (Including referral costs and commission paid to attorney/collection agencies).

Release of Dental Records:
Prior authorization is required before any dental records are released by the patient signing a "release consent" form.

- If a patient requests their dental records for their own records a charge of $35.00 is required.
- If a patient requests their dental records for another dental/medical office, our team will fax and email the records to the dental/medical office.

Full Name (Printed): ___________________________ DOB: _________________________

Signature: ____________________________________ Date: _________________________