SMART MOUTH
FAMILY DENTAL

Welcome to Smart Mouth Family Dental! Please take a few minutes to fill out the form. If you have any questions, we are glad to assist you.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___

Gender: M / F Date of Birth: _____ SSN: _____ Driver's License#: _____

Street Address: _____ City: _____ State: _____ Zip: ___

Email: _____ Home Phone: _____ Cell Phone: _____

Employer Name: _____Employer Phone: _____

Married: Y / N Emergency Contact:_____ Phone: _____

How did you hear about our office? _____

RESPONSIBLE PARTY

If the patient is under 18 years old, please complete the following:

Last Name _____:First Name: _____Middle Initial: _____

Date of Birth: _____Gender: M / F Married: Y / N SSN: _____

Driver's License#: _____Email Address: _____

INSURANCE POLICY

Patient Relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name: _____Subscriber ID#: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____Group#:_____

FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance and receive payment directly from 1hcm. If sent to collections, I agree to pay all related fees and court costs. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. Treatment plans may change, and I will be responsible for the work done. I understand that all fees are payable at the time of treatment.

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices Consent to Use and Disclose Protected Health Information.

Notice of Privacy Practices

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purpose of Treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal Privacy Standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on with your revocation of consent is received will NOT be affected.

Printed Name: _____

Signature: _____

Date: _____

I Authorize Smart Mouth Family Dental to discuss and/or release my medical/dental information including lab and test results, diagnosis, and treatments discussed to the following persons. Also, I authorize to discuss my account information including account balances, insurance, statements, and payment options to the same persons.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Witness Signature: _____

MEDICAL HISTORY

Name of Medical Doctor: _____ City/St: _____ Last visit: _____

List any medications you are now taking:

( ) None

_____

_____

_____

_____

_____

Check medications or drugs you are allergic to:

( ) None
( ) Aspirin
( ) Codeine /Narcotics
( ) Erythromycin
( ) Latex
( ) Local Anesthetics
( ) Metals
( ) Penicillin
( ) Sulfa Drugs
( ) other:_____

Are you taking blood thinners? Y/N

Check any medical conditions you may have:

( ) None
( ) AIDS/HIV
( ) Alcohol/Drug Abuse
( ) Anemia Leukemia
( ) Anorexia/Bulimia
( ) Arthritis
( ) Autism
( ) Asthma/Hay Fever
( ) Blood Clotting Problems
( ) Blood Transfusion
( ) Bronchitis
( ) Cancer/Tumor or Growth
( ) Cardiac Pacemaker
( ) Chest pain upon exertion
( ) Damaged Heart Valve
( ) Diabetes *Last A1C* :_____
( ) Emphysema
( ) Epilepsy
( ) Fainting/seizures
( ) Fever Blisters/Herpes
( ) Frequent Headaches
( ) Frequent Dry Mouth
( ) Gallbladder Trouble
( ) Heart Attack/Stroke
( ) Heart Disease/Angina
( ) Heart Murmur
( ) Hepatitis/Jaundice
( ) High Blood Pressure
( ) Hives/Skin Rash
( ) HPV
( ) Joint Replacement *Date* :_____
( ) Kidney/bladder trouble
( ) Liver Disease
( ) Low Blood Pressure
( ) Mental Health Problems
( ) Mitral Valve Prolapse
( ) Persistent Diarrhea
( ) Rheumatic Fever
( ) Rheumatic Heart Disease
( ) Sexually Transmitted Disease
( ) Sinus Trouble
( ) Stomach Ulcers
( ) Thyroid Problems
( ) Tuberculosis
( ) History of sleep apnea? If yes, do you wear a CPAP? ___

***Are you taking or have you taken bisphosphonates (e.g., Fosamax) for osteoporosis?** Y/ N

Do you gums bleed? Y / N
Do you have a history of TMJ or grinding/clenching your teeth? Y / N
Unusual reaction to dental injections? Y / N
Women: Are you pregnant? Y / N
Are you taking birth control pills? Y / N

Reason for today's visit: _____
*Are you in pain? Y/N
*Date of Last Dental Visit: _____
*Do you like nitrous oxide? Y/N
*How happy are you with your smile? *Not happy* 1 2 3 4 5 6 7 8 9 10 *Very happy*

I certify that I have read and understand the above questions and acknowledge the questions have been answered to the best of my knowledge.

Signature: _____
Date:_____