Patient Information

Patient Name ____________________ DOB ___/___/___ Sex *(Please circle)* M F

Pronouns __________ Email ____________________ Phone ______________

Mailing Address ____________________ Marital Status *(Please circle)* S M D W

Occupation ______________ Employer ______________ SSN ____-____-____

Primary Care Provider ______________ Primary Pharmacy ______________

How did you hear about us? ______________ Reason for visit ______________

Medical History

(Please circle yes or no)

Abnormal Bleeding	Yes No	Convulsions	Yes No	Hepatitis A	Yes No	Sinus Problems	Yes No
Alcohol/Drug Abuse	Yes No	Cosmetic Surgery	Yes No	Hepatitis B or C	Yes No	STD/STI	Yes No
Alzheimer's disease	Yes No	Depression/Anxiety	Yes No	Herpes/Cold Sores	Yes No	Stroke	Yes No
Anemia	Yes No	Diabetes	Yes No	High Blood Pressure	Yes No	Thyroid Problems	Yes No
Angina Pectoris	Yes No	*If yes, last A1C:* ______		High Cholesterol	Yes No	Radiation Treatment	Yes No
Arthritis/Gout	Yes No	Emphysema	Yes No	HIV/AIDS	Yes No	Renal Dialysis	Yes No
Artificial Heart Valve	Yes No	Epilepsy/Seizures	Yes No	Kidney Problems	Yes No	Tonsilitis	Yes No
Artifical Joints	Yes No	Fainting Spells	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Asthma	Yes No	Frequent Headaches	Yes No	Mitral Valve Prolapse	Yes No	Tumor/Growth	Yes No
AutoImmune Disease	Yes No	Glaucoma	Yes No	Osteoporosis	Yes No	Ulcers	Yes No
Blood Disease	Yes No	Hay Fever	Yes No	Jaw Pain	Yes No	Valley Fever	Yes No
Blood Transfusion	Yes No	Heart Attack	Yes No	Psychiatric Care	Yes No	Yellow Jaundice	Yes No
Breathing Problems	Yes No	Heart Murmur	Yes No	Prostate Disorder	Yes No		
Cancer	Yes No	Heart Pacemaker	Yes No	Rheumatic Fever	Yes No		
Chemotherapy	Yes No	Heart Shunt/Stent	Yes No	Shingles	Yes No		
Congenital Heart Defect	Yes No	Hemophilia	Yes No	Sickle Cell Disease	Yes No		

Other ____

Current Medications ____

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Past Medical History

- Have you ever had a serious neck or head injury? Yes No
- Have you ever been hospitalized or had a major operation? Yes No
- Have you taken drugs for weight loss such as Phenfen? Yes No
- Have you ever taken medications that contain Bisphosphonates such as Fosamax? Yes No
- Do you smoke or use tobacco products? Yes No
- Are you often exhaused or fatigued? Yes No
- Are you currently taking birth control pills? Yes No
- Are you currently pregnant? Yes No
  If yes, how many # of weeks? ______

Allergies

Amoxicillin	Yes No	Fluoride	Yes No
Aspirin	Yes No	Latex	Yes No
Chlorhexidine	Yes No	Metals	Yes No
Codeine	Yes No	Penicillin	Yes No
Dental Anesthetics	Yes No	Sulfa Drugs	Yes No
Erythromycin	Yes No	Tetracycline	Yes No

Other Allergies ______________________

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PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient/Guardian's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Patient Name ______________________________

- **What is your primary dental concern (if any)?** ______________________________

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- **When was your last cleaning and exam?** ______________________
- **When was your last full mouth x-rays completed (14 or more)?** ______________________
- **Are any of your teeth sensitive to:**

☐ **Cold** ☐ **Hot** ☐ **Sweets** ☐ **Biting or Pressure**

Dental History

- **Are you interested in cosmetic dentistry?** Yes No
- **Are you currently happy with your smile?** Yes No
- **Do you currently wear dentures or partials?** Yes No
- **Have you ever had periodontal treatment for gum disease?** Yes No

If yes, please describe: ______________________________

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- **Do you feel any teeth that are loose?** Yes No
- **Have you noticed any swelling/tenderness in your gums?** Yes No
- **Do you avoid either side while chewing or brushing?** Yes No
- **Do your gums bleed during or after brushing?** Yes No
- **Are you aware that you clench or grind your teeth?** Yes No

If yes, please circle: Day or Night

- **Does your jaw feel tired, especially in the morning?** Yes No
- **Have you ever been treated for TMJ problems?** Yes No
- **Do you have pain in the front of or above your ears?** Yes No
- **Do you have all or most of your natural teeth?** Yes No
- **Have your missing teeth (if any) been replaced?** Yes No

If yes, please describe: ______________________________

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- **If your missing teeth have not been replaced, are you concerned about the possible outcome?** Yes No
- **Do you use dental floss or a water flosser?** Yes No
- **Do you have a fear of dentistry?** Yes No
- **Do you take premedication for dental procedures?** Yes No
- **Is there any more information you feel as though we should know about?** ______________

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Patient/Guardian's Signature ______________________________ **Date:** ______________

Consent for Treatment, Payment, and Practice Operations

Welcome to Caring Smiles Studio, we are glad that you have chosen our office as your dental provider and would love to provide you with the best possible dental care and services. To better help you become familiar with our office we would like to address areas that we feel are most important.

- **I give this practice my consent to use or disclose my protected health information to carry out any dental treatment and to obtain payment from insurance companies.**
- **I have been informed that I may review the practice's 'Notice of Privacy Practices' for a more complete description of uses and disclosures before providing my consent.**
- **I understand that this practice has a right to change their privacy practices and that I may retain any revised notices of the practice.**
- **I understand that I may revoke consent at any time, by making a request in writing. Such a request will not apply to any information already used or disclosed prior to the request.**
- **We take great pride in reserving your appointment in advance, and it is extremely important that you maintain your scheduled appointment. We ask that you please provide our office a 24-hour notice in the event that you need to reschedule. If an appointment is missed without notifying the office within the required time, a fee of $75 will be charged to you. This fee cannot be billed to insurance and will be your direct responsibility. For any more than 3 missed appointments, the patient relationship with our office may be terminated.**
- **It is our office policy that payment is expected at the time the service is rendered. As a courtesy to you, we will bill your insurance company and accept their payments, along with your co-payments, at each appointment. However, the ultimate investment for services lies strictly with the patient. Any discrepancy between our estimation of your insurance benefits and the actual payments lies between you and your insurance company. If the insurance company has not paid their portion within 30 days, we ask that the payment be made in full by the patient. We do accept ALL major credit cards, as well as, Care Credit as viable payment options.**

Patient/Guardian's Signature ______________________________ **Date:** ____________

Consent for Photography

I, ________________________________ the undersigned, do hereby authorize and consent to the use of certain photographs/x-rays of me taken by the dental team at Caring Smiles Studio. I hereby grant them permission to reproduce, publish, print, use, and distribute copies of such photographs/x-rays in official medical publication, or in the form of prints, slides, film, or for use in connection with articles, lectures, or social media posts dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy, which might occur to me on account of the use of such pictures without my expressed consent in each instance.

NO FULL FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE

Polaroid photographs taken during treatment are used by our laboratories for cosmetic purposes in order to fabricate crowns, bridges, or dentures, and are a part of your permanent dental record.

Please select one of the following:

- ☐ I do NOT consent to the use of slides/photography for use in dental education or publications.
- ☐ I do consent to the use of slides/photography for use in dental education or publications including full face or identifying views.
- ☐ I do consent to the use of slides/photography for use in dental education or publications EXCEPT full face or identifying views.

Patient/Guardian's Signature ________________________________ Date: ______________

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claim.

Patient Name: ________________________ **Date:** ____________

Please list any parties who are actively involved in your health care and who you give permission to access your health information (This includes stepparents, grandparents, and/or any other caretakers who can access this patient's records)

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

I authorize contact from this office to confirm my appointments, treatments, and billing information via:

- ☐ **Cell Phone Confirmation Call**
- ☐ **Text Message to my Cell Phone**
- ☐ **Home Phone Confirmation Call**
- ☐ **Email Confirmation**
- ☐ **Work Phone Confirmation Call**
- ☐ **Any of the above**

I approve being contacted about special services, events, fundraising efforts, or new health information on behalf of this Healthcare Facility via:

- ☐ **Phone Message**
- ☐ **Text Message**
- ☐ **Email**
- ☐ **Any of the above**
- ☐ **None of the above**

In signing this HIPAA Patient Acknowledgement form, you may acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party renumeration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this Healthcare Facility. A copy of this signed and dated document shall be as effective as the original.

My signature will also be served as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

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Patient Name (Printed) **Signature of Patient/Patient Guardian**

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Legal Guardian/Representative **Relationship of Legal Guardian/Representative**

*For Office Only: As Privacy Officer, I attempted to obtain the patient's (or patient representative's) signature on this Acknowledgment but did **not** because:*

- ☐ *It was Emergency Treatment*
- ☐ *I could not communicate with the patient*
- ☐ *Patient refused to sign*
- ☐ *Patient was unable to sign*