THE SMILE INSTITUTE

PATIENT INFORMATION

Patient Name _____ SSN _____ Date _____
LAST FIRST MI

Birth Date _____ Gender [M] [F] Email _____

Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Phone (Home) _____ (Work) _____ Ext. _____ Cell / Other _____

Emergency Contact _____
NAME RELATIONSHIP PHONE NUMBER

RESPONSIBLE PARTY INFORMATION

Name _____ SSN _____ Birth Date _____
LAST FIRST

Gender [M] [F] ☐ Married ☐ Single ☐ Child ☐ Other _____

Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Phone (Home) _____ (Work) _____ (Cell) _____ Best time to call _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Name of Insured _____ SSN _____
LAST FIRST MI

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

Insured's Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Insured's Employer Name & Address _____

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

Insurance Plan Name & Address _____

SECONDARY INSURANCE CARRIER

Name of Insured _____ SSN _____
LAST FIRST MI

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

Insured's Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Insured's Employer Name & Address _____

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

Insurance Plan Name & Address _____

Medical History Questionnaire

Patient Name: _____ Date: _____

Reason for appointment: _____

Who referred you to our office: _____

Please answer all questions by checking the YES or NO box. Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
❑	❑	High blood pressure
❑	❑	Heart disease from childhood
❑	❑	Heart murmur
❑	❑	Rheumatic fever
❑	❑	Use of Phen-Fen
❑	❑	Pacemaker
❑	❑	Vascular graft
❑	❑	Heart valve replacement
❑	❑	Heart attack
❑	❑	Heart surgery
❑	❑	Congestive heart failure
❑	❑	Angina (chest pain)
❑	❑	Irregular heart beat
❑	❑	Stroke
❑	❑	Increased cholesterol

Endocrine/Hematologic/Oncologic/Immune:

YES	NO	
❑	❑	Frequent hunger
❑	❑	Frequent thirst
❑	❑	Diabetes
❑	❑	Thyroid disease
❑	❑	Hemophilia
❑	❑	Sickle cell disease
❑	❑	Bleeding tendency
❑	❑	Anemia
❑	❑	Cancer
❑	❑	Radiation therapy
❑	❑	Chemotherapy
❑	❑	HIV infection/AIDS
❑	❑	Organ transplant
❑	❑	Blood transfusion

Do you have, or did you ever have, any of the following?

Musculo-Skeletal/CNS/Developmental

YES	NO	
❑	❑	Chronic jaw and facial pain?
❑	❑	Chronic headache pain?
❑	❑	Chronic neck pain?
❑	❑	Popping or clicking in your jaw?
❑	❑	Joint replacement
❑	❑	Osteoarthritis
❑	❑	Rheumatoid arthritis
❑	❑	Spinal cord injury
❑	❑	Seizures
❑	❑	Dizziness
❑	❑	Weakness
❑	❑	Multiple Sclerosis
❑	❑	Cerebral palsy
❑	❑	Mental retardation
❑	❑	Dementia / Alzheimer's
❑	❑	Fainting spells
❑	❑	Visual impairment
❑	❑	Glaucoma
❑	❑	Hearing impairment

GI/GU:

YES	NO	
❑	❑	Hepatitis (A, B, C, or other?)
❑	❑	Kidney dialysis
❑	❑	Ulcers
❑	❑	Sexually transmitted disease
❑	❑	Denied permission to give blood
❑	❑	Gastroesophagal disease (Gerd)

Psychological:

YES	NO	
❑	❑	Anxiety/Nervousness
❑	❑	Depression
❑	❑	Mental health treatment
❑	❑	Insomnia

Do you have, or have you ever had, any of the following?

Respiratory:

YES	NO	
❑	❑	Asthma
❑	❑	Chronic Sinus Problems
❑	❑	Night sweats
❑	❑	Emphysema
❑	❑	Tuberculosis

Other:

_____

Social:

YES	NO	
❑	❑	Do you use tobacco products?
		If so, how much?_____
❑	❑	Do you drink alcohol?
❑	❑	Every day?
		If so, how much?_____
❑	❑	Do you use recreational drugs?

Medication Allergy or Intolerance:

YES	NO	
❑	❑	Penicillin
❑	❑	Dental anesthetic ("Novocain")
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Latex products
❑	❑	Iodine
❑	❑	Sulfa Drugs

Other: _____

Do you have any medical condition(s) not already mentioned?

_____

_____

History of Hospitalization/Surgical Procedures:

_____

_____

Family: Has a parent, sibling, or child of yours ever had any of the following?

YES	NO	
❑	❑	Diabetes
❑	❑	High blood pressure
❑	❑	Heart disease
❑	❑	Bleeding tendency
❑	❑	Cancer

Medications:

YES	NO	
❑	❑	Are you taking any prescription medicines, any over-the-counter items, or any herbal medicines now?

If so, please list them and the doses you use:

_____

_____

_____

_____

_____

_____

_____

_____

Other:

YES	NO	
❑	❑	Does the amount of saliva in your mouth seem to be too little?
❑	❑	Does your mouth feel dry when eating a meal?

FEMALES ONLY:

YES	NO	
❑	❑	Are you pregnant now?
		If so, #_____ months
❑	❑	Do you take birth control pills?
❑	❑	Are you breast feeding now?

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medications, I will inform my The Smile Institute Practice dental health care provider at my next appointment.

Signature of patient (or Parent of Guardian if patient is under 18) **Date**

_____ _____

Doctor Signature **Date**

_____ _____

THE SMILE INSTITUTE

FINANCIAL POLICY

Thank you for choosing The Smile Institute to meet your dental needs. Our goal is to create a relaxed environment where we provide comprehensive dental care by leading edge practitioners who not only practice dentistry, but also teach and are involved in research to improve oral health.

Non-insured Patients:

Payment in full is required at the time of service. However, we will make payment arrangements for major procedures. These arrangements must be made **before** treatment is started.

Insured Patients:

We accept most dental plans but It is your responsibility to know your benefits and coverage, including yearly maximums, waiting periods, and any other coverage exceptions or limitations. However, we will contact your insurance carrier to verify your benefits and determine your estimated coverage. This is usually a rough estimate because the insurance company does not have to reveal the maximum fee it will reimburse for services, generally referred to as the UCR or the usual and customary rate/fee. As a courtesy, we will file your claim and require that the benefits be assigned directly to our office. We expect you to pay the uncovered portion of your services the day your services are rendered. If your insurance carrier has not paid their portion within 60 days you are immediately responsible for the balance in full. **You are responsible for any amount your insurance does not pay.**

All Patients:

Our fees are subject to change. Any outstanding balance not paid at the time services are rendered, will be turned over to our collection agency after 60 days. The patient or person responsible for the account agrees to pay any administrative fees, attorney fees, court costs, or any other costs of collection. Accounts sent to our collection agency are subject to a 15% Collection and/or Attorney Fee. Any accounts having a balance over 45 days past due will be assessed an interest of 12% APR.

Cancellation and Rescheduling policy

Please be advised that we require 24-hour notice be given to reschedule or cancel appointments. If 24-hour notice is not given, you may be subject to a $50 per appointed hour charge. We confirm appointments within two days to one week of your appointment, depending on your dental service type. We request a call back for confirmation of scheduled appointments.

I have read this financial policy and accept the content.

Please Print Name: _____

_____ _____

Patient/Responsible Party Signature Date

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