



## Patient Information

Welcome to our office! We appreciate the confidence you place with us to provide your dental services. To assist us in serving you, please complete the following form which will aid us in assessing your overall dental health. Our staff members will be happy to answer any questions you may have regarding this form, our policies or our services.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer / Occupation: \_\_\_\_\_ Preferred method of contact: Ph Email Txt

### Insurance Information *(if applicable)*

Dental Insurance Company: \_\_\_\_\_  
 Subscriber's Name: \_\_\_\_\_ Relation: Self / Spouse / Parent  
 Subscriber's Member ID or SSN: \_\_\_\_\_  
 Patient's Member ID or SSN (if different from above): \_\_\_\_\_

### Dental History

|   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Are you apprehensive about dental treatment?                      | <input type="checkbox"/> | <input type="checkbox"/> | Are you dissatisfied with the appearance of your teeth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had problems with previous dental treatments?            | <input type="checkbox"/> | <input type="checkbox"/> | Do you prefer to save your teeth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you gag easily?  | <input type="checkbox"/> | <input type="checkbox"/> | Do you want complete dental care?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear dentures?   | <input type="checkbox"/> | <input type="checkbox"/> | Does your jaw make noise so that it bothers you or others?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Does food catch between your teeth?                               | <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your jaws frequently?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have difficulty in chewing your food?                      | <input type="checkbox"/> | <input type="checkbox"/> | Does your jaw get stuck so that you can't open freely?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you chew on only one side of your mouth?                       | <input type="checkbox"/> | <input type="checkbox"/> | Do you have earaches or pain in front of the ears?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you avoid brushing any part of your mouth because of pain?     | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any jaw symptoms or headaches upon awaking in the morning?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed easily?  | <input type="checkbox"/> | <input type="checkbox"/> | Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed when you floss?                                | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a temporomandibular (jaw) disorder (TMD)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums feel swollen or tender?                              | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a blow to the jaw (trauma)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever noticed slow-healing sores in or about your mouth?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Do you feel twinges of pain when your teeth come in contact with: |                          |                          |  |                          |                          |
| Hot food or liquids?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Cold foods or liquids?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Sours?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Sweets?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

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

|  | Yes                      | No                       |  |                          |                          |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Heart Problems   | <input type="checkbox"/> | <input type="checkbox"/> | <b>Are you allergic, or have you reacted adversely, to any of the following?</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure problem   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart valve problem  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking heart medication  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Problems   | <input type="checkbox"/> | <input type="checkbox"/> | Codeine, Demerol, or other narcotics   | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy bruising  | <input type="checkbox"/> | <input type="checkbox"/> | Reaction to metals   | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nosebleeds  | <input type="checkbox"/> | <input type="checkbox"/> | Latex or rubber dam  | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal bleeding  | <input type="checkbox"/> | <input type="checkbox"/> | Other _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease (anemia)   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Ever require a blood transfusion?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Allergy Problems   | <input type="checkbox"/> | <input type="checkbox"/> | <b>During the past 12 months, have you taken any of the following?</b>           | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay fever  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin rashes  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking allergy medication  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone or Joint Problems   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Back or neck pain  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement (e.g., total hip, pins, or implants)   | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney or bladder problems   | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting Spells, Seizures, or Epilepsy   | <input type="checkbox"/> | <input type="checkbox"/> | Digitalis or drugs for heart trouble   | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke(s)  | <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerin  | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent or severe headaches   | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone (steroids)   | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems   | <input type="checkbox"/> | <input type="checkbox"/> | Natural remedies   | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough or swollen glands   | <input type="checkbox"/> | <input type="checkbox"/> | Nonprescription drug/supplements   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Premedications required by physician</b>  | <input type="checkbox"/> | <input type="checkbox"/> | Other _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/Tumor   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> | <b>Women</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes   | <input type="checkbox"/> | <input type="checkbox"/> | Are you taking contraceptives or other hormones?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis or other respiratory disease  | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke?  | <input type="checkbox"/> | <input type="checkbox"/> | If so, expected delivery date: _____   |                          |                          |
| If so, how much? _____   |                          |                          | Are you nursing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice, or liver trouble  | <input type="checkbox"/> | <input type="checkbox"/> | Have you reached menopause?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes or other STD  | <input type="checkbox"/> | <input type="checkbox"/> | If so, do you have any symptoms? _____   |                          |                          |
| HIV-positive/AIDS  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Epilepsy or other neurological disease?  | <input type="checkbox"/> | <input type="checkbox"/> | <b>Notes:</b> _____  |                          |                          |
| History of alcohol or drug abuse?  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Do you have any disease, condition, or problem not listed previously that you feel we should know about? |                          |                          | _____  |                          |                          |
| If so, please describe: _____  |                          |                          | _____  |                          |                          |
| _____  |                          |                          |  |                          |                          |
| _____  |                          |                          |  |                          |                          |
|  |                          |                          | <b>Patient/Parent Signature:</b> _____   |                          |                          |
|  |                          |                          | Dentist Initial: _____   |                          |                          |



## Financial Agreement

Thank you for choosing One Smile Dental for your dental health needs!

In an effort to serve you better, we have payment plans available and clear and transparent financial policies. If you have any questions regarding either, please ask one of our front office staff for clarification.

1. Payment or payment arrangement is due at the time treatment is rendered. We accept Cash, Check, Mastercard, Visa, Discover and CareCredit. Returned checks will incur a \$30.00 bank fee.
2. For our patients with dental insurance: We will complete your insurance form and submit it to the insurance company. Your estimated co-payment for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointment, we ask that you pay your bill in full and be reimbursed from your insurance company with paperwork. Our office cannot guarantee your dental insurance company will pay for the treatment you receive. We make every effort to obtain accurate information from your carrier, but in the event a claim is denied, down-coded or alternate benefits given, the Responsible Party will be responsible for paying the full balance amount left on the account at that time. Any uncollected credits from insurance adjustments will remain on the account for one year before a check will be issued to the Responsible Party. \_\_\_\_\_ (please initial)
3. Monthly payment options: If you require long-term payment options, we offer applications for CareCredit plans with up to 12 months NO INTEREST financing as well as other terms with competitive interest rates. We also offer a limited, short-term payment plan with a credit card on file.

I assign directly to One Smile Dental, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. One Smile Dental may use my health care information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. I authorize One Smile Dental to process credit card transactions initiated by me either by mail, email or in person.

Thank you for giving us the opportunity to serve your dental needs. If you have any questions regarding this form, please ask one of our front office staff.

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Printed name of Responsible Party

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Signature of Responsible Party

Date



## Notice of Privacy Policies

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

We take your privacy very seriously in our office. Please take a moment to answer a couple questions so we may better understand how you would like us to handle your information:

- May we text, email or leave a voicemail regarding your treatment and account?  
Yes / No
- Any other people we may disclose information regarding your treatment or account?  
None / Spouse / Other: \_\_\_\_\_
- If you are referred to a dental specialist or other healthcare professional, do you authorize the release of your x-rays, records, contact and insurance information?  
Yes / No

How did you hear about us? \_\_\_\_\_

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I have had full opportunity to consider the contents of the Notice of Privacy Policies and HIPAA Privacy Rule. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission in writing at any time.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date