One Smile
DENTAL

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
Are you apprehensive about dental treatment?	❑	❑
Have you had problems with previous dental treatments?	❑	❑
Do you gag easily?	❑	❑
Do you wear dentures?	❑	❑
Does food catch between your teeth?	❑	❑
Do you have difficulty in chewing your food?	❑	❑
Do you chew on only one side of your mouth?	❑	❑
Do you avoid brushing any part of your mouth because of pain?	❑	❑
Do your gums bleed easily?	❑	❑
Do your gums bleed when you floss?	❑	❑
Do your gums feel swollen or tender	❑	❑
Have you ever noticed slow-healing sores in or about your mouth?	❑	❑
Do you feel twinges of pain when your teeth come in contact with:		
Hot food or liquids?	❑	❑
Cold foods or liquids?	❑	❑
Sours?	❑	❑
Sweets?	❑	❑

	Yes	No
Are you dissatisfied with the appearance of your teeth?	❑	❑
Do you prefer to save your teeth?	❑	❑
Do you want complete dental care?	❑	❑
Does your jaw make noise so that it bothers you or others?	❑	❑
Do you clench or grind your jaws frequently?	❑	❑
Does your jaw get stuck so that you can't open freely?	❑	❑
Do you have earaches or pain in front of the ears?	❑	❑
Do you have any jaw symptoms or headaches upon awaking in the morning?	❑	❑
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	❑	❑
Do you have a temporomandibular (jaw) disorder (TMD)?	❑	❑
Have you had a blow to the jaw (trauma)?	❑	❑

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

	Yes	No
Heart Problems	❑	❑
Chest pain	❑	❑
Shortness of breath	❑	❑
Blood pressure problem	❑	❑
Heart murmur	❑	❑
Heart valve problem	❑	❑
Taking heart medication	❑	❑
Rheumatic fever	❑	❑
Pacemaker	❑	❑
Artificial heart valve	❑	❑
Blood Problems	❑	❑
Easy bruising	❑	❑
Frequent nosebleeds	❑	❑
Abnormal bleeding	❑	❑
Blood disease (anemia)	❑	❑
Ever require a blood transfusion?	❑	❑
Allergy Problems	❑	❑
Hay fever	❑	❑
Sinus problems	❑	❑
Skin rashes	❑	❑
Taking allergy medication	❑	❑
Asthma	❑	❑
Bone or Joint Problems	❑	❑
Arthritis	❑	❑
Back or neck pain	❑	❑
Joint replacement (e.g., total hip, pins, or implants)	❑	❑
Kidney or bladder problems	❑	❑
Fainting Spells, Seizures, or Epilepsy	❑	❑
Stroke(s)	❑	❑
Frequent or severe headaches	❑	❑
Thyroid problems	❑	❑
Persistent cough or swollen glands	❑	❑
Premedications required by physician	❑	❑
Cancer/Tumor	❑	❑
Diabetes	❑	❑
Family history of diabetes	❑	❑
Tuberculosis or other respiratory disease	❑	❑
Do you smoke?	❑	❑
If so, how much? _____		
Hepatitis, jaundice, or liver trouble	❑	❑
Herpes or other STD	❑	❑
HIV-positive/AIDS	❑	❑
Glaucoma	❑	❑
Epilepsy or other neurological disease?	❑	❑
History of alcohol or drug abuse?	❑	❑

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

_____

_____

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Aspirin, Acetaminophen, or Ibuprofen	❑	❑
Codeine, Demerol, or other narcotics	❑	❑
Reaction to metals	❑	❑
Latex or rubber dam	❑	❑

Other _____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	❑	❑
Anticoagulants (e.g., Coumadin)	❑	❑
High blood pressure medicine	❑	❑
Tranquilizers	❑	❑
Insulin, Orinase, or similar drug	❑	❑
Aspirin	❑	❑
Digitalis or drugs for heart trouble	❑	❑
Nitroglycerin	❑	❑
Cortisone (steroids)	❑	❑
Natural remedies	❑	❑
Nonprescription drug/supplements	❑	❑

Other _____

Women

	Yes	No
Are you taking contraceptives or other hormones?	❑	❑
Are you pregnant?	❑	❑
If so, expected delivery date: _____		
Are you nursing?	❑	❑
Have you reached menopause?	❑	❑

If so, do you have any symptoms? _____

_____

Notes: _____

_____

_____

_____

Patient/Parent Signature: _____

Dentist Initial: _____

One Smile
DENTAL

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.

_____

Printed name of Responsible Party

_____

Signature of Responsible Party Date

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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 l·yŘ consider the contents of the NotiǾe of Privacy Policies ayŘ ŰKŜ 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