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www.SmileMoreToday.com

All information is kept strictly confidential. We cannot share any information you give us to a third party without your approval.

About You

Patient Name: ____
First MI Last Preferred Name

Social Security Number: ____________________ Date of Birth: ____________
000-00-0000 mm/dd/yyyy

Email address: ____

Phone: ____
Home Cell Work

Address: ____
Street Apt # City State Zip Code

Employer: ____________________________ Occupation: ____________

Emergency Contact: ____
First Last Relationship

Phone: ____
Home Cell Work

Medical Insurance Information

Dental Benefits Company: ________________ Toll Free Phone Number: ________

Are you the subscriber? ☐Yes ☐No (if yes, skip to Group Number)

Subscriber: ____
First Last Social Security Number Date of Birth

Group Number: ______________ Subscriber ID Number (may be SSN): __________

How Did You Hear About Us? (Please select all that apply)

☐Through a friend or family member

What is their Name? ____
First Last

☐Through our TV commercial

☐On Comcast ☐On RCN

☐Through my dental benefits

☐On the Internet

☐Google ☐Yahoo ☐Yelp ☐CitySearch ☐Facebook ☐Emergency Dentist 24/7

☐Other

Please describe: ______________________________

Health History

Physicians Name: ___________________________________ Phone Number: __________________________________

Are you currently under this physicians care? ☐Yes ☐No

If Yes, what is the purpose of the current care being provided? ____

Do you have heart disease or a heart problem? ☐Yes ☐No Do you have a family history? ☐Yes ☐No

If yes, please describe: ____

Have you ever had or do you currently have any of the following conditions?

Yes	No		Yes	No	
☐	☐	Bleeding Problems	☐	☐	Organ Transplant
☐	☐	Breathing Problems	☐	☐	HIV / AIDS
☐	☐	Cancer/Radiation Treatment	☐	☐	Joint Replacement
☐	☐	Diabetes			

Is it under control? ☐ Yes ☐ No Are you prone to diabetic complications? ☐ Yes ☐ No

How do you monitor your blood sugar? ________________________

Who treats your diabetes? ___________________________________

Yes	No		Yes	No	
☐	☐	Family History of Diabetes	☐	☐	Hepatitis
☐	☐	Snoring / Sleep Apnea	☐	☐	Psychiatric Treatment
☐	☐	High/Low Blood Pressure	☐	☐	Stroke
☐	☐	High Cholesterol	☐	☐	Obesity
☐	☐	Excessive hunger	☐	☐	Frequent Urination
☐	☐	Excessive thirst	☐	☐	Unexplained weight loss
☐	☐	Slow healing of cuts	☐	☐	Weakness & fatigue
☐	☐	Bad breath			

Any other medical conditions, please describe: ____

Has a physician or dentist ever recommended you take antibiotics before dental treatment? ☐Yes ☐No

Do you now or have you ever used the following:

☐Cigarette ☐Cigar ☐Pipe ☐Chew

If so, how much per day? _______________ How many years? ______________If you quit, list what year_____________

Are you allergic or have you had a bad reaction to any of the following?

Yes	No	
☐	☐	Local anesthetic (novacaine)
☐	☐	Penicillin
☐	☐	Latex
☐	☐	Anything else (please describe): ________________________________

Do you smoke? ☐Yes ☐No Do you get regular exercise? ☐Yes ☐No

What medications are you taking right now and for what condition? (include prescription and over the counter): example: Prilosec for acid reflux

____

Female Patients:

Are you pregnant? ☐Yes ☐No

Are you nursing? ☐Yes ☐No

Are you currently taking birth control? ☐Yes ☐No

Are you menopausal? If so, are you taking estrogen/hormone replacement therapy? ☐Yes ☐No

Are you currently taking any medication to increase bone density? ☐Yes ☐No

Dental History

Why are you here today? ____

Who was your last dentist? Dr. ____________________ When was the last time you saw a dentist? __________

Why did you decide to change dentists? ____________________________________

Have you ever had an unpleasant dental experience? ☐Yes ☐No
(if yes, please describe) ____

How is your current dental health?

- ☐ Good
- ☐ Average
- ☐ Needs Improvement
- ☐ Not sure

Do your gums bleed when you brush or floss?

- ☐ Never
- ☐ Sometimes
- ☐ Almost every time

What do you want to improve with your smile?

- ☐ Whiteness
- ☐ Staining/Discoloration
- ☐ Evenness of Teeth
- ☐ Chipping or Cracking
- ☐ Existing Dental Work
- ☐ Gum Health/Appearance/Smile Line (Do you see enough/too much of your smile?)
- ☐ Replace missing teeth
- ☐ Straighten teeth
- ☐ Pain/Discomfort

If you could change anything about the appearance of your smile, what would it be?

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General Office Information

With your permission, we may take x-rays and photographs to evaluate your dental health. Video and audio recording devices may be used to monitor consultations and treatment to ensure a high quality experience for all of our patients. We will not share any of your personal information with anyone outside of this office without your consent.

24-Hour Cancellation Policy

When we reserve time for your appointment, we make room in our schedule so we may devote our time and focus our efforts on serving your needs. Late cancellations mean we have empty time in our schedule when we could have been helping another patient. There is a $25 charge for reserved appointments broken or changed without 24 hours notice.

I understand and agree with the Office Policies of Smile More Today.

____

Printed Name

____

Signature of patient, parent or guardian		Date		Relationship to patient

Financial Policy

You are responsible for the **total fee** for services performed at this office. Cash and all major credit cards are accepted as payment for services at Smile More Today. Checks are accepted with a valid credit card on file.

If you have benefits, we will provide an **estimate** of what we think your benefits company will **probably** pay and collect the difference from you at the time of service. If you want a more exact estimate, we will need to send a request for a **pre-treatment estimate** to your benefits company. This can take several weeks to be returned to us.

If the benefits company pays more than we expected, you will have a credit on your account. We will mail you a statement informing you of the credit. You can keep it on your account or we can refund it to you. All outstanding benefit claims must be received before we may issue any refunds.

If the benefits company pays less than we expected or not at all, **you are responsible** for the difference between what you have already paid and your total fee.

We will try to arrange payment from your benefits company for a maximum of 30 days. **After 21 days, you are responsible for any balance on your account, regardless of whether your benefits company has paid us or not.**

If we receive payment after 21 days from your benefits company, it will be applied to your account and you will receive a statement from us informing you of any credit generated by the payment.

After 90 days from the date of service, any unpaid balance will be turned over to a collection agency. This is our standard policy for all delinquent accounts. Once an account is sent to collections, you must pay the collection agency. You will no longer be able to pay us directly for the balance.

Stop! Do not sign this if you have any questions about the financial policies of our office. If you do have questions, ask one of our financial coordinators before signing.

In accordance with HIPAA, I agree to Smile More Today use and disclosure of my protected health information to my benefits company. I understand that my benefits company will send payment directly to Smile More Today unless prior arrangements have been made.

I understand and agree with the Financial Policies of Smile More Today.

____

Printed Name

____

Signature of patient, parent or guardian | Date | Relationship to patient