Patient Medical History

Patient name:			**Today's date:**
Date of birth:	**Pt Height:**	**Patient Weight:**	**Date of last physical exam:**
Home Address:			**Date of last dental exam:**
Email Address:		**Phone Number:**	**Emergency contact name:**
Family Doctor:		**Doctor Phone:**	**Emergency contact phone number:**

Please List Your Medications Below:			
Medication	**Reason**	**Dosage**	**Frequency**

Female Patients:	**Yes**	**No**
Are you currently Pregnant?		
Are you currently Nursing?		
Are you taking Birth Control?		

If you are using oral contraceptives, it is important to understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Please consult with your physician for further guidance.

Do you have any of the following Heart related conditions?	**Yes**	**No**
Prosthetic cardiac valve?		
Prosthetic material used for cardiac valve repair?		
Previous infective endocarditis or rheumatic fever?		
Unrepaired cyanotic congenital heart disease (including shunts and conduits)?		
Completely repaired congenital heart defect with prosthetic material within the last 6 months?		
Repaired congenital heart disease with residual defects at the site or adjacent to the site of a prosthetic patch or device that inhibits endothelialization?		
Cardiac transplantation that has developed cardiac valvulopathy?		
Artificial joints or surgically placed prosthesis placed within the last 2 years? If yes, when:		

Are you taking any of the following	**Yes**	**No**	**Unknown**
Antibiotics?			
Anticoagulants (blood thinners)?			
Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?			
Steroids (Cortisone, etc.)?			
Digitalis, Inderal, Nitroglycerin or other heart drug?			
Are you taking or have you ever taken bisphosphonates (Fossamax, Actonel, Boniva, Aredia, Zomets)?			

Do you have any of the following?	**Yes**	**No**	**Unknown**
Implant placed anywhere in your body?			
Have you ever required pre-medication or antibiotics for a dental appointment?			

Do you have any of the following Allergies?	**No**	**Unknown**		**Yes**	**No**	**Unknown**
Allergy to latex?			Allergy to sedatives or barbiturates?			
Allergy to nickel, acrylic or other?			Allergy to aspirin or ibuprofen			
Allergy to any medications or foods?			Allergy to codeine or other pain killers?			
Please List:						

Do you have any of the following respiratory	**Yes**	**No**	**Unknown**
Asthma? (If yes answer a, b and c)			
a) If yes are you steroid dependent?			
b) Do you use an inhaler?			
c) Do you have your inhaler with you?			
Emphysema?			
Sinus Problems?			
Seasonal allergies or hay fever?			
Airway obstructions?			

Patient Medical History

Please answer the following medical history questions:	Yes	No		Yes	No
Are you currently under a physician care?			Bone, joint, or muscular problems?		
Have you been hospitalized for any reason in the last 5 years?			Facial or Jaw trauma?		
Any disease, drug, or operation that has depressed your immune system?			Any problems with local anesthesia?		
			Fainting with local anesthesia?		
Difficulty with intubation during general anesthesia?			Allergy to local anesthesia?		
Do you use tobacco?			If so, what happened?		
If yes how many a day: For how many years:			Difficulty getting numb?		
Do you have a history of tuberculosis?			History of paresthesia?		
High blood pressure?			Neurological Disorders?		
Low blood pressure?			History of Seizures?		
Angina?			If yes, when was your last seizure?		
History of a heart attack?			Epilepsy?		
History of a stroke?			If yes, when was your last seizure?		
Coronary Artery disease?			Mental or emotional problems?		
Arrhythmias?			Habitual drug or alcohol use?		
Rheumatic heart disease?			HIV positive/ AIDS?		
Rheumatic Fever?			Have you had an infection in the last two weeks?		
Heart murmur?			What kind of infection?		
Congenital heart defects?			Liver disease?		
Mitral valve prolapse?			Hepatitis A?		
Artificial heart valves?			Hepatitis B?		
Pacemaker?			Hepatitis C?		
Heart Surgery?			Stomach or duodenal ulcer?		
Do you have any of the following blood conditions:			GERD (Gastro Esophageal Reflux Disease)?		
Blood dyscrasias (abnormal blood cells)?			Colitis?		
Sickle cell anemia?			Kidney disease?		
Thyroid problems?			Kidney stones?		
Glaucoma?			Head or neck injury involving bones, nerves or disks that disabled you for a week or longer?		
Diabetes?					
If yes, are you on insulin?			Do you snore?		
Is your diabetes currently controlled?			Have you been diagnosed with sleep apnea?		
Are you currently taking oral medications for diabetes?			Do you use a CPAP machine?		
Arthritis?			Cancer?		
If yes, for how long?			What type?		
Osteoporosis?			Chemotherapy? Radiation? Other?		
Do you have any medical conditions not listed above? Please List:					

Please list medical conditions that exist in your family:

Mom: _____

Dad: _____

Siblings: _____

Other, list relation: _____

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Dentistry REIMAGINED

Patient Dental History

	Yes	No	Unknown	Comments
Are you experiencing pain from your mouth at this time?				
Do your gums bleed? (If Yes answer a)				
a) When?				
Have you ever had an acute sore mouth or "trench" mouth?				
Are you aware of a bad taste or odor in your mouth?				
Are you troubled with frequent "gum boils"?				
Cold Sores?				
Oral Herpes?				
Xerostomia (dry mouth)?				
Did your mother, father, brother or sister lose all their natural teeth?				
Are you satisfied with the appearance of your teeth?				
Have you ever had a severe toothache?				
Are you bothered by tooth sensitivity? Hot, cold, sweets?				
Does food catch between your teeth?				
Do tartar and stain return quickly?				
Do cavities develop rapidly?				
Can you chew satisfactorily?				
Do you chew on both sides of your mouth?				
Do you have any particular mouth habits? Lip, cheek, or tongue biting, foreign objects between teeth, etc.?				
Are you conscious of any habit with your tongue?				
Do you clench or grind your teeth?				
Do you awaken in the morning with your teeth together, tired jaws, numb feeling in your teeth, or pain in your jaw?				
Do your teeth come together evenly?				
Are you conscious of sore, loose or shifting teeth?				
Are you conscious of any high or rough teeth or fillings?				
Do you ever have pain opening or closing your mouth?				
Does your jaw ever go, "out of joint"?				
Have you ever had any teeth removed?				
Did you have the missing tooth or teeth replaced?				

I understand the importance of reporting a truthful health history to assist Smilebuilderz staff in providing the best care possible and acknowledge that the information I have provided is accurate to the best of my knowledge.

Printed Patient Name

Signature of Patient or Responsible Party Date

SMILEBUILDERZ APPOINTMENT POLICY

Welcome to the Smilebuilderz dental family! As a member of our family, we are committed to providing you with the very best oral health care in addition to exceptional customer service. Missed appointments compromise our ability to provide you the quality of care and service we are committed to.

- A **missed** appointment is when *you do not attend* a scheduled appointment.
- A **rescheduled** appointment is when you *change* a scheduled appointment without giving 24 hours' notice.

We ask that you have no more than ***two*** rescheduled appointments with less than 24 hours' notice, and no more than ***one*** missed appointment in any twelve month period to maintain the privilege of scheduling your appointments. We will help remind you of your appointments through text message, email or courtesy phone call.

Help us keep our commitment to you by making your scheduled appointments a priority.

By signing below I acknowledge my responsibility in maintaining the privilege of scheduling and the impact of missing or rescheduling my dental appointments on the ability of Smilebuilderz to maintain their commitment to my oral health.

Signature of Patient or Responsible Party Date

SMILEBUILDERZ COMMITMENT

We are an elite team of professionals who set the standard for providing quality oral healthcare solutions. We are committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health.

Our Smilebuilderz family is committed to:

- Delivering the **highest quality of care.**
- Providing specialties in Endodontics, Orthodontics, Periodontics, and Oral Surgery allows us to deliver exceptional comprehensive care.
- Being **accountable** to you for each and every procedure.
- Offering you **convenient** evening and weekend appointments and emergency walk-in care seven days a week.
- Providing affordable dentistry
- Utilizing the most **up-to-date technology** and materials available.

Our goal is to be *your partner in health for a lifetime.* We take our responsibility and commitments to you very seriously. We ask that you strive for the following:

- To be committed to the appointment time you have reserved.
- To be aware that any patient under 18 years of age will need to be accompanied by a legal guardian at all appointments.
- To be prepared with the appropriate estimated out of pocket expense at your appointment.
    - Any estimated out of pocket expense of $500.00 or greater requires half down to be scheduled and the remaining balance will be due at the time of the appointment.
    - Half of the estimated out of pocket is due at time of scheduling for specialty services.
- Notify us as soon as possible if you will be delayed by 5 minutes or more for any appointment.
- Understand that all charges incurred on your account are your responsibility regardless of insurance coverage. Unpaid Insurance balances older than 60 days will become your responsibility. All fees quoted are estimates only and are based upon available benefits, current eligibility and are not a guarantee of payment from your insurance provider.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO SMILEBUILDERZ.

_____

Printed Name of Patient

_____

Signature of Patient or Responsible Party Date

SMILEBUILDERZ FINANCIAL POLICY

Thank you for choosing Smilebuilderz as your dental health care provider. We are committed to the success of your treatment. Part of the commitment is your understanding and responsibility for the payment of your account balance.

Our basic financial policy is the following:

FULL PAYMENT OF ESTIMATED RESPONSIBILITY IS DUE AT THE TIME OF SERVICE.
Smilebuilderz accepts cash, check, Visa/MasterCard, Discover, American Express and special financing through Care Credit.

ADULT PATIENTS:

Adult patients are responsible for full payment of estimated responsibility at the time of service unless specific arrangements are made prior to the start of treatment.

MINOR PATIENTS:

The parent accompanying a minor and the parents/guardians are responsible for full payment of estimated responsibility at time of service.

REGARDING INSURANCE:

We will accept assignment of participating insurance plans and will submit dental claims on our patient's behalf. Your insurance policy is a contract between you and your insurance company. Smilebuilderz is not a party to that contract. Any insurance bill not settled within 60 days will be due in full. You agree to pay our practice all amounts billed regardless of the amount covered by your insurance.

Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider. Our estimate of expected coverage does not constitute a representation or guarantee that your benefit provider will pay the amount estimated.

USUAL AND CUSTOMARY RATES

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will take reasonable and proper steps to help you receive the maximum insurance benefits allowed by your insurance plan.

PATIENT RESPONSIBILITY AND ADDITIONAL TERMS

If you fail to comply with the terms of this financial policy and Smilebuilderz pursues collection of your unpaid balance, you agree to pay, in addition to any balance due, all collection costs incurred by the practice, including but not limited to, collection fees, court costs and reasonable attorney's fees.

The listed items are custom-made for you by our laboratories and cannot be refunded in full if you decide to discontinue treatment. You agree to be assessed the accompanying fees in lieu of your full treatment price for the following procedures if not completed within six calendar months.

Partials/Dentures……$300
Implant Crowns and Custom Abutments……...$700
All other undelivered services…..…….$150

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to the terms of the Financial Policy of the office of Smilebuilderz, LLC.

Signature of Patient or Responsible Party **Date**

Signature of Co-Responsible Party **Date**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Printed Name of Patient

Signature of Patient or Responsible Party (Parents or Legal Guardians) Date

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

RELEASE OF INFORMATION

I,_____, authorize Smilebuilderz to release my information to the following:

Name	Relationship	Date	Initials
Name	Relationship	Date	Initials
Name	Relationship	Date	Initials
Name	Relationship	Date	Initials