New Patient Information

Welcome to Complete Smile Dentistry! We are so glad you have chosen us to meet and exceed your dental expectations. Please take this time to complete our patient registration, including the insurance information if you have not already given it to one of our staff members.

Name

Last _____ First _____MI _____

Nickname_____ Email _____

Male _____Female _____ Married _____ Single _____ Child _____ Birthdate_____

Social Security# _____

Driver's License #_____

Address

Street _____City _____ State _____Zip_____

Home#_____Work#_____Cell#_____

Employer _____Occupation_____

Address_____ How Long There?_____

Insurance Information

Subscriber #_____Social Security#_____ DOB_____

Insurance Co. _____Group#_____Phone#_____

Subscriber Employer _____

MEDICAL HISTORY Do you have a personal physician? _____

Are you currently under a physician's care?____

Physician's Name_____Physician's Phone #_____

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD _____ FAIR _____POOR ____

Do you smoke or use tobacco in any form? Yes ___ No ___

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Do you have any implant , valves, rod or pins? Yes ___No___

Are you taking any medication? Yes ___No___

Please List: _____

FOR WOMEN: Are you taking birth control pills? Yes___No___

Are you pregnant? Yes__ No__ Week#:_____ Are you nursing ? Yes __ No__

Have you ever had any of the following diseases or Medical problems? (please check all that apply

☐ Alcohol/Drug Abuse	☐ Anemia	☐ Hepatitis	☐ Arthritis
☐ High Blood Pressure	☐ Ulcers	☐ HIV / AIDS	☐ Asthma
☐ Kidney Problems	☐ Bleeding Problems	☐ Liver Disease	☐ Blood Transfusion
☐ Low Blood Pressure	☐ Cancer/Chemo	☐ Mitral Valve Prolapse	☐ Congenital Heart Defect
☐ Pacemaker	☐ Diabetes	☐ Psychiatric Problems	☐ Difficulty Breathing
☐ Heart Murmur	☐ Emphysema	☐ Rheumatic Fever	☐ Epilepsy
☐ Seizures	☐ Fainting/Dizzy Spells	☐ Shingles	☐ Sickle Cell Trait/Disease
☐ Migraines	☐ Heart Attack	☐ Sinus Problems	☐ Radiation Treatment
☐ Stroke	☐ Hemophilia	☐ Artificial Joints/Valves	☐ Herpes

Please list any serious medical condition(s) that are not listed above: (if none, please write NONE)

_____

_____

Are you allergic to any of the following? (Please Check) (if none, please write NONE)

☐ Aspirin	☐ Erythromycin	☐ Metals	☐ Dental Anesthetics	☐ Codeine
☐ Penicillin	☐ Jewelry	☐Sulfra	☐ Latex	☐ Tetracycline

Questions or concerns?

_____

_____

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DENTAL HISTORY
What is the primary reason for your visit today?
_____

Are you currently in pain? Yes __ No __
Do you require antibiotics before dental treatment? Yes__ No__

YOUR CURRENT DENTAL HISTORY IS:
GOOD_____ FAIR_____POOR____

When was the last time you had a complete dental evaluation?_____
Have you ever had a serious/difficult problem associated with any previous dental work? Yes__ No__
Do you floss regularly? Yes__ No__
Brush Daily? Yes__ No__

Have you ever been informed or treated for the following?

☐ Bleeding Gums	☐ Osseous Surgery	☐ Mobility of Teeth
☐ Bad Taste / Odor	☐ Cold Sores / Ulcers	☐ Deep Cleaning / Scaling
☐ Wisdom Teeth Extract	☐ TMI /TMD Join Pain	☐ Gum/Periodontal Disease
☐ Oral Cancer / Biopsy	☐ Hot/Cold Sensitivity	☐ Toothbrush Abrasion

Would you like fresher breath? Yes__ No__
Would you like whiter teeth? Yes__ No __
Are you happy with how your smile looks? Yes__ No__
If not, what would you change?_____

WORK AUTHORIZATION & FINANCIAL POLICY
The undersigned hereby authorizes the Doctor to take x-rays, study, models photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risks. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a Finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor. We respect that your time is valuable, please respect ours also, therefore, if appointments are continuously cancelled or charged without a 48hr notice; we require a reservations fee for future appointments.

Patient's (Parent) Signature _____
Date _____
Dentist Initials _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. PATIENTS RIGHTS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. You may request a copy of our Notice at any time.

Do we have your permission to send your information pertaining to our services by email? Yes____ No____

Do we have your permission to remind you by telephone or email of any appointment at home or mobile number? Yes____ No____

Do we have your permission to discuss any health information related to you with your family member, friend, or other person? Yes____ No____

By my signature below, I acknowledge that I have received the Notice of Privacy Practices from the office Complete Smile.

_____

Name

_____

Signature

_____

Date

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PATIENT AGREEMENT FORM

Thank you for choosing Complete Smile as your dental treatment provider. In order to facilitate your treatment here we ask that you read and sign this agreement. If you have any questions, please ask for clarification.

For the patients with dental insurance, we will gladly verify and process your dental insurance with the following agreement:

- Your dental insurance is an agreement between you and your insurance
- company
- All patient copayments and/or patient portions are only an estimate and never
- guarantee of payment.
- As part of your contract with your insurance company, you are responsible for all
- out-of-pocket fee / deductibles and copayments.
- Insurance payments not paid after 90 days will become your complete responsibility and must be paid in full.

Missed Appointment or Short Notice Cancellations/ Reschedules:

We understand that your plans/ schedules can change. When they do, please contact us at least **48 hours** in advance. A fee of **$50** will be charged to cancellations/reschedules with less than 48 hours or with no notice prior to your appointment. Because we are not in the position to determine if an excuse is valid or not, **no exceptions** will be made to this policy. It is the patient's ultimate responsibility to keep their scheduled appointment. By my signature below, I acknowledge that I have reviewed the patient agreement form and agree to the terms and policies.

_____

Name

_____

Signature

_____

Date

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