Smile Dental Center — Health Questionnaire

Patient Name: _____ Birth Date: _____

Patient Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient e-mail: _____ SS#: _____

Primary Physicians Name/Address: _____

Reason for coming: _____ Whom may we thank for your referral: _____

CHECK APPROPRIATE ANSWER (leave blank if you do not understand question)	**YES**	**NO**
Are you in good general health?	☐	☐
Have you been instructed or have the need to be pre-medicated for any dental procedure?	☐	☐
Have you ever had any artificial joint replacement?	☐	☐
Has there been a change in your health within the last year?	☐	☐
Have you been hospitalized or had a serious illness in the last three years?	☐	☐
If YES, why? _____		
Are you being treated by a physician now? For what? _____	☐	☐
Date of last medical exam? _____ Date of last dental exam? _____		
Please list all allergies. _____		

Medical Information

DO YOU OR HAVE YOU HAD:	**YES**	**NO**		**YES**	**NO**
Chest pain (angina)?	☐	☐	Dizziness?	☐	☐
Swollen ankles?	☐	☐	Ringing in the ears?	☐	☐
Shortness of breath?	☐	☐	Headaches?	☐	☐
Recent weight loss, fever, night sweats?	☐	☐	Fainting spells?	☐	☐
Persistent cough, coughing up blood?	☐	☐	Blurred vision?	☐	☐
Bleeding problems, bruising easily?	☐	☐	Seizures?	☐	☐
Sinus problems?	☐	☐	Excessive thirst?	☐	☐
Difficulty swallowing?	☐	☐	Frequent urination?	☐	☐
Diarrhea, constipation, blood in stools?	☐	☐	Dry mouth?	☐	☐
Frequent vomiting, nausea?	☐	☐	Jaundice	☐	☐
Difficulty urinating, blood in urine?	☐	☐	Joint pain, stiffness?	☐	☐

WOMEN ONLY:	**YES**	**NO**
Are you or could you be pregnant or nursing?	☐	☐
Taking birth control pills?	☐	☐

DO YOU OR HAVE YOU HAD:	YES	NO		YES	NO
Heart disease?	☐	☐	AIDS	☐	☐
Heart attack, heart defects?	☐	☐	Tumors, cancer?	☐	☐
Heart murmurs?	☐	☐	Arthritis, rheumatism?	☐	☐
Rheumatic fever?	☐	☐	Eye disease?	☐	☐
Stroke, hardening of the arteries?	☐	☐	Skin disease?	☐	☐
High blood pressure?	☐	☐	Anemia?	☐	☐
Asthma, TB, emphysema, COPD?	☐	☐	VD (syphilis or gonorrhea)?	☐	☐
Hepatitis, other liver diseases?	☐	☐	Herpes?	☐	☐
Stomach problems, ulcers?	☐	☐	Kidney, bladder disease?	☐	☐
Allergies to drugs, foods, latex?	☐	☐	Thyroid, adrenal disease?	☐	☐
Psychiatric care?	☐	☐	Diabetes?	☐	☐
Radiation treatments?	☐	☐	Blood transfusions?	☐	☐
Chemotherapy?	☐	☐	Surgeries?	☐	☐
Prosthetic heart valve?	☐	☐	Pacemaker?	☐	☐

DO YOU OR HAVE YOU HAD:	YES	NO		YES	NO
Chronic face pain?	☐	☐	Pain when chewing or opening mouth?	☐	☐
Clicking/popping jaw?	☐	☐	Catching of food between teeth?	☐	☐
Difficulty opening or closing jaw?	☐	☐	Recent toothache / sensitivity?	☐	☐
Difficulty chewing?	☐	☐	Uncomfortable bite?	☐	☐
Blisters/sores on lips or mouth?	☐	☐	Recent need to chew on one side?	☐	☐
Unpleasant taste/bad breath?	☐	☐	Clenching / grinding?	☐	☐
Burning tongue / lips?	☐	☐	Loose teeth?	☐	☐
Swelling or lumps in mouth?	☐	☐	Orthodontic treatment (Braces)?	☐	☐
Bleeding or infected gums?	☐	☐	Gum treatment or surgery?	☐	☐

ARE YOU TAKING:	YES	NO		YES	NO
Recreational drugs?	☐	☐	Tobacco in any form?	☐	☐
Drugs,medications (including aspirin)?	☐	☐	Alcohol?	☐	☐

List all prescription and non-prescription drugs (including aspirin) taken within the last 6 months:

Name and dosage _____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability.

Patients Signature: _____ Date: _____ Doctor Signature: _____

(If minor, parent or responsible party)

Medical History Update:

Patient Signature: _____ Date: _____ Doctor Signature: _____

Patient Signature: _____ Date: _____ Doctor Signature: _____

Patient Signature: _____ Date: _____ Doctor Signature: _____

Dental Insurance Information

Primary Carrier

Name of Insured: _____ Is insured a patient? YES ☐ NO ☐

Insured's Birth Date: _____ ID # _____ Group # _____ SS # _____

Insured's Address: _____

Insured's Employer: _____

Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

Insurance Plan Phone # _____

If you have Secondary Insurance, Complete this section

Name of Insured: _____ Is insured a patient? YES ☐ NO ☐

Insured's Birth Date: _____ ID # _____ Group # _____ SS # _____

Insured's Address: _____

Insured's Employer: _____

Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

Insurance Plan Phone # _____

Photography Release

I hereby authorize Dr. Mario Pary / Smile Dental Center, to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including but not limited to website publications, newspapers, magazines, phone books, television), and professional publications (dental journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature: _____ Date: _____

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.
Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, and Visa. Outside financing is available upon request and approval.

Please check if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In case it becomes necessary for our office to enlist a collection service and / or legal assistance, you will be responsible for any collection and / or legal charges incurred up to 35%.

-As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

-All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

-Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

-We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

-We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, or Visa at the time we provide the service to you. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

-We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. **Our office will not, however, enter into a dispute with your insurance company over any claim.**

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.
I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize 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 a certain risk. **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, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature: _____

(If minor, parent or responsible party)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)

_____

_____

_____

Print Form