



## WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

### About You

Name \_\_\_\_\_  
(First) (MI) (Last)

Mr.  Mrs.  Ms.  Dr. I prefer to be called:

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

What is your preferred method of contact? \_\_\_\_\_

Who may we thank for referring you \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

### Responsible Party's Information

His/Her Name: \_\_\_\_\_  
(First) (MI) (Last)

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Dental Insurance

#### Primary Dental Insurance

Name of Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

#### Secondary Dental Insurance

Name of Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB:        /        /

Are you currently under the care of a physician? If YES, Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Describe your current physical health:     Excellent     Fair     Poor

Do you Smoke or use Smokeless Tobacco?     Yes     No                      Specify: \_\_\_\_\_

FOR WOMEN: Are you taking birth control pills?     Yes     No

Are you pregnant?     Yes     No    If yes, # of weeks \_\_\_\_\_                      Are you nursing?     Yes     No

Y     N    Have you ever taken Boniva or Alendronate (Fosamax)? \_\_\_\_\_

Are you currently taking any                       prescriptions                       over the counter drugs                       herbal supplements                       appetite suppressants?

Do you now or have you ever had any of the following medical conditions?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease / Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia                | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis / Osteopenia    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur           | <input type="checkbox"/> Y <input type="checkbox"/> N Leukemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach / Intestinal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Irregular Heart Beat   | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies (Seasonal)      | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Angina / Chest Pain    | <input type="checkbox"/> Y <input type="checkbox"/> N Pain in the Jaw           | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Seizures       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack           | <input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease              | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Failure          | <input type="checkbox"/> Y <input type="checkbox"/> N Breathing Problems        | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes - type: _____       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever        | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)         | <input type="checkbox"/> Y <input type="checkbox"/> N Hypoglycemia                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse  | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems            | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma - type: _____      | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis - type: _____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Pacemaker        | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                 | <input type="checkbox"/> Y <input type="checkbox"/> N Jaundice                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery          | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure    | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting / Dizziness      | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis - type: _____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure     | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                    | <input type="checkbox"/> Y <input type="checkbox"/> N Drug Use / Addiction         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease          | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment       | <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Addiction            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                 | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores / Fever Blisters  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily          | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joint: _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Nervousness                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                 | <input type="checkbox"/> Y <input type="checkbox"/> N AIDS / HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Depression                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding     | <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease: _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Other: _____                 |

Are you allergic to any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin     | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex            | <input type="checkbox"/> Y <input type="checkbox"/> N Other: _____ |

Y  N Have you ever been hospitalized or had any major operations? \_\_\_\_\_

Please list any over-the-counter or prescription drugs that you are currently taking.

Medication	Dosage	Reason for Taking Medication

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental History

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain or discomfort with your teeth and/or gums?  Yes  No

How would you describe the condition of your teeth and gums?  Excellent  Fair  Poor

Previous Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Have you had orthodontics?  Yes  No If YES, at what age? \_\_\_\_\_

Do you have headaches?  Yes  No If YES, how often? \_\_\_\_\_

## Questionnaire

Y  N Do you understand the correlation between dental plaque control and the prevention of gum disease?

Y  N Do your gums ever bleed?

Y  N Have you ever been told you have gum disease?

Y  N Do you often feel your breath is not as fresh as it could be?

Y  N Do you grind or clench your teeth?

Y  N Have you ever had pain/discomfort in your jaw joint?

Y  N Do you snore or have you been told you do?

Y  N Do you sleep well? How long? \_\_\_\_\_

Y  N Would you like to have whiter teeth?

Y  N Would you like your teeth to be straighter?

Y  N Are you unhappy with any silver or discolored fillings?

Y  N Do you have crowns or bridges which are unattractive or unnatural looking?

Y  N Do you sometimes feel uncomfortable with the appearance of your smile?

Y  N Are your teeth crooked or crowded?

Y  N Do you think a more attractive smile would improve your personal and/or professional relationships?

Y  N Are you afraid or anxious to visit the dentist?

Y  N Do you wish that you could feel relaxed at your next dental appointment?

What level of dental care do you think your dental insurance company will cover?  Excellent  Fair  Poor

What level of dental care would you like to have for yourself?  Excellent  Fair  Poor

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at Creative Smiles for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

**If the patient is less than 18 years of age, a parent or legal guardian must sign.**

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices  
(Please Print Patient's Name)

\_\_\_\_\_  
(Signature of Patient or Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

**For Patients who need pre-medication only:**

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whomever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

\_\_\_\_\_  
(Signature of Patient or Parent/Legal Guardian)

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### For Office Use Only

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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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Patient reviewed Privacy Practices, but elected not to take a copy home
- Other (Please Specify)

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# CS | CREATIVE SMILES

## OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dual insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Minors **MUST** be accompanied by an adult for all treatment.

We accept CASH, CHECKS, VISA, AMERICAN EXPRESS, and MASTERCARD. Financing is also available upon request, prior to treatment.

In most instances, we accept assignment of insurance benefits, in which case your portion of each service is due at the time services are rendered. Those who have dual coverage should discuss their payment plans with the receptionist. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance.

### **YOU MUST REALIZE, HOWEVER, THAT:**

1. YOUR insurance is a contract between you, your employer, and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) or where "UCR" is defined as Usual, Customary and Reasonable fees for this region; thus, most insurance companies consider our fees Usual, Customary, and Reasonable. However, this statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard cost-of-care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Should your insurance take longer than 60 days to pay, we ask that you take care of the balance due and then be reimbursed, if and when we receive the insurance payment.

Returned checks are subject to an **additional \$35 fee**.

**Missed Appointments.** Because office time and materials are reserved for you, a fee may be assessed for a missed appointment not canceled **at least 48 hours in advance**. The first such fee will be \$40.00; subsequent fees will be charged at our current hygiene rate. Please help us serve our patients efficiently by keeping your scheduled appointments or giving us as much advance notice as possible of a conflict in your schedule.

We must emphasize that, as dental care providers, our relation is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the day the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, ***please*** don't hesitate to ask us. **We are here to help you!**

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**RESPONSIBLE PARTY SIGNATURE**

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**NAME OF PATIENT**

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**NAME OF RESPONSIBLE PARTY (if different from patient)**

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**DATE**

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**PRINTED NAME OF RESPONSIBLE PARTY**