WELCOME TO SMILE BY DESIGN

Please tell us about yourself

Name: _____ _____ _____ _____
Last First MI Title

Preferred Name: _____ ○ Male ○ Female

Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Whom may we thank for referring you?: _____

Do you prefer to be contacted for appointment confirmation via e-mail, text message, or phone?: _____

Person to Contact in Case of Emergency? _____ Phone _____

Responsible Party

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Contact # _____ DOB _____

Employer _____ Work Phone _____ SSN _____

Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber SSN/ID: _____

Subscriber Employer: _____ Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Do you have additional dental insurance? _____

Responsible Party Signature: _____ Date: _____

DENTAL HISTORY FOR

_____

LAST FIRST MI

How may we help you today? _____

Do you clinch or grind your teeth?	o Yes o No
Do you wear a nightguard?	o Yes o No
Do you have any pain/discomfort/clicking in your jaw? (TMJ)	o Yes o No
Have you ever had periodontal treatment?	o Yes o No
Do you have bad breath or dry mouth?	o Yes o No
Do you have blisters or sores in your mouth?	o Yes o No
Do you have pain in any of your teeth?	o Yes o No
Are your gums swollen, tender or bleeding?	o Yes o No
Are your teeth sensitive to heat, cold, biting or anything else?	o Yes o No
Do you have any loose teeth or broken fillings?	o Yes o No
Have you ever had orthodontic treatment?	o Yes o No

How many times do you: floss/week? _____ brush/day? _____

When was your last dental cleaning?_____

When/Where were last dental xrays taken?_____

Here at Smile by Design, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below that you would like our friendly staff to discuss with you during your visit.

- CROWN AND BRIDGE
- DENTAL IMPLANTS
- PARTIALS/DENTURES
- NIGHT/SPORT GUARDS
- INVISALIGN
- WHITENING

MEDICAL HISTORY FOR

LAST _____ FIRST _____ MI _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). o Yes o No

Do you have a personal physician? o Yes o No

Physician's name: _____

Physician's phone: _____

Date of last visit: _____

Have you ever been hospitalized for any surgical or serious illness within the last 5 years? o Yes o No

If yes, please explain: _____

Do you use tobacco in any form? o Yes o No

Do you use any controlled substances? o Yes o No

Are you taking any medications? o Yes o No

If yes, please list each one: _____

_____

_____

Pharmacy Name: _____ Pharmacy #: _____

Do you need to Pre-Med with antibiotics for any of the below conditions?** _____

Yes	No	Conditions
o	o	Abnormal Bleeding
o	o	Actonel
o	o	Allergies
o	o	Anemia
o	o	Angina Pectoris
o	o	Arthritis
o	o	Artificial Heart Valve
o	o	Asthma
o	o	Boniva
o	o	Cancer
o	o	Chemotherapy Colitis
o	o	Congenital Heart
o	o	Diabetes
o	o	Difficulty Breathing
o	o	Drug Abuse/Alcohol
o	o	Emphysema
o	o	Epilepsy
o	o	Fainting Spells
o	o	Fosamax
o	o	Frequent Headaches
o	o	Glaucoma
o	o	HIV+ AIDS
o	o	Heart Attack
o	o	Heart Murmur **
o	o	Heart Surgery
o	o	Hemophilia

Yes	No	Conditions
o	o	Hepatitis A
o	o	Hepatitis B
o	o	Hepatitis C
o	o	High Blood Pressure
o	o	Hip Replacement**
o	o	Joint Replacement**
o	o	Kidney Problems
o	o	Knee Replacement**
o	o	Liver Disease
o	o	Low Blood Pressure **
o	o	Mitral Valve Prolapse
o	o	Pace Maker
o	o	Psychiatric Problems
o	o	Radiation Therapy
o	o	Reclast
o	o	Rheumatic Fever**
o	o	Seizures
o	o	Sinus Problems
o	o	Stroke
o	o	Thyroid Problems
o	o	Tuberculosis
o	o	Ulcers
o	o	Venereal Disease

Other :_____

Yes	No	Allergies
o	o	Aspirin
o	o	Codeine
o	o	Dental Anesthetics
o	o	Erythromycin
o	o	Jewelry
o	o	Latex
o	o	Metals
o	o	Penicillin
o	o	Tetracycline

Other: _____

If Female, Please Answer:

Yes	No	
o	o	Are you taking Birth Control Pills?
o	o	Are you pregnant? If so, # of weeks: _____
o	o	Are you nursing?

Treatment and Financial Responsibility Statement

Please read carefully

Thank you for choosing Smile By Design as your dental provider. We pride ourselves on providing all patients with excellent dental services. To keep you informed of our current financial policies, please read the following, initial each policy and sign at the bottom.

INSURANCE: _____INITIAL
I understand that my insurance policy is a contract between my insurance company and me, and that I am financially responsible to Smile By Design (Stephanie L. Santos, DDS and Vinita J. Folck, DDS), for any fees not covered by insurance.
We are committed to providing you with the best possible dental care available. If you have dental insurance, we are pleased to help you receive your maximum allowable benefits. To do this, we need your assistance and your understanding of our payment policy.

COPAYS, DEDUCTIBLES, AND NON-COVERED SERVICES: _____INITIAL
All estimated copays, deductibles, and non-covered services are due at time of service. These charges cannot be waived by our practice, as they are a requirement placed on you by your insurance carrier. You are responsible for any non-covered services as determined by your insurance plan. Although we file claims for most insurance plans on your behalf, you are ultimately responsible for payment of the bill.

ALTERNATIVE BENEFIT: _____INITIAL
Some insurance policies will downgrade a service to the least costly option available. This occurs commonly with tooth colored fillings and porcelain crowns. Amalgam fillings and metal crowns are less costly and some insurance plans are carefully crafted to reduce the insurance company's expenditure by specifying they will only pay for the least costly correction even though this treatment may not be in the patient's best interest. You are responsible for the difference.

PAST DUE BALANCES: _____INITIAL
You will be asked to pay any past due balances when making appointments or before seeing the dentist. If your balance is especially high, we set up a three (3) month payment plan. A service charge may be applied to any account that has an unpaid balance after 60 days.

MISSED APPOINTMENTS: _____INITIAL
Cancellation of an appointment less than 24 hours before it is scheduled will result in a broken appointment fee. Also, if a patient misses a scheduled appointment a fee may be charged to the patients account at the doctor's discretion.
We request a courtesy of advanced notice so that we can contact other patients who also needs dental care. Inability to keep your appointments prevents another patient from receiving treatment. If a patient has three missed or cancelled short notice appointments they risk being dismissed from our practice.

COLLECTION POLICY: _____INITIAL
In the event of default on any payments due to Smile by Design, I agree to pay all costs of collection including, but not limited to an attorney fee of 35% of the balance owing at the time of referral. All past due accounts may be charged a service charge of 1.75% per month on the unpaid balance (21% per annum).

Thank you for understanding and accepting our Financial Policy.
We accept cash, checks, American Express, VISA, Mastercard, Discover, and Care Credit.

Responsible Party Signature:_____ Date:_____

SMILE BY DESIGN

A Division of Atlantic Dental Care

Privacy Practices Acknowledgment

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures of health information.

Printed Name _____

Signature _____

Date _____

HIPAA Acknowledgment

I understand that by signing this Consent form, I am giving my consent to Smile by Design to disclose and discuss my protected health information with another professional entity so they may assist me with my healthcare issues.

Printed Name _____

Signature _____

Date _____

If this consent form is signed by a personal representative (parent/guardian) on behalf of the patient, please complete the following:

Parent/Guardians Name _____

Relationship to Patient _____

***REVOKE**: I revoke my consent for your use and disclosure of my protected health information*

Patients Signature: _____ Date: _____

If this consent form is signed by a personal representative (parent/guardian) on behalf of the patient, please complete the following:

Parent/Guardians Name _____

Relationship to Patient _____