New Pt Form

Patient Information

First Name
-

Middle Initial
-

Last Name
-

Preferred Name
-

Gender
-

Date of Birth
-

Social Security Number
-

Driver's License
-

Phone Numbers:

Home Phone
-

Work Phone
-

Ext
-

Cell Phone
-

Email
-

Home Address: (NOTE: P.O. Box addresses are not accepted)
-

Street Address
-

City
-

State
-

ZIP Code
-

Are you a student?
-

If Yes, Name of School:
-

Marital Status
-

If Minor, Name of responsible guardian:
-

Relationship to patient:
-

In case of emergency contact name:
-

Phone number:
-

Occupation:
-

Emplover:
-

Emplover Address:
-

Whom may we thank for referring you to our office?
-

Insurance Information

Primary

Name of Insured:
-

If no insurance just type None above
-

Patient relationship to insured:
-

Insured Birth Date:
-

Insured social security# (or ID#):
-

Insured Employer Name:
-

Employer Phone#:
-

Group #
-

Insurance plan name & Address:
-

Insurance co. phone#:
-

Secondary

Name of Insured:
-

Patient relationship to insured:
-

Insured Birth Date:
-

Insured social security# (or ID#):
-

Insured Employer Name:
-

Employer Phone#:
-

Group #
-

Insurance plan name & Address:
-

Insurance co. phone#:
-

Medical History

1) Do you have or ever had any of the following?

AIDS/HIV Infection
-

Alcohol Dependency
-

Anemia
-

Angina/Chest Pain
-

Arthritis/ Rheumatism
-

Asthma
-

Blood Disease
-

Blood Transfusion
-

Cancer
-

Chemical Dependency
-

Chemotherapy
-

Cortisone Treatment
-

Diabetes
-

Epilepsy
-

Glaucoma
-

Hay Fever/Allergies
-

Headaches (frequently)
-

Date
-

Heart Attack
-

Heart Disease
-

Heart Murmur
-

Hemophilia
-

Hepatitis
-

Type:
-

High Blood Pressure
-

Joint/hip Replacement
-

Date
-

Kidney Disease
-

Liver Disease
-

Mental Disorders
-

Mitral Valve Prolapse
-

Pacemaker
-

Prosthetic Heart Valve
-

Radiation Treatment
-

Respiratory Disease
-

Rheumatic Fever
-

Sexually Transmitted Disease
-

Shortness of Breath
-

Sinus Problems
-

Stomach Problems/ Ulcers
-

Stroke
-

Date
-

Thyroid Disease
-

Tuberculosis
-

Tumors
-

Have you taken, plan to take or currently on Prolia (Denosumab)?
-

If yes, Please specify timeline:
-

Other:
-

2) Are you allergic to or have you had any reactions to the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic (e.g. Novocain)
- ☐ Metals (e.g. nickel, mercury,etc.)
- ☐ Nitrous
- ☐ Penicillin
- ☐ sulfa Drugs
- ☐ Tetracycline
- ☐ I Do Not Have Any Known Allergies "
- ☐ other

(please list):.
-

3) Are you taking any medication(s) including non-prescription drugs?
-

If yes, please list medications /supplements:
-

4) Date of last physical exam:
-

Physician's Name:
-

Office Phone#:
-

5) Are you under medical treatment now?
-

If yes, please explain:
-

6) Have you been hospitalized for any surgical operation or serious illness during the past five years?
-

If yes, please explain:
-

7) Do you use tobacco?
-

9) Do you or have you taken Bisphosphonates (e g. Fosamax, Actonel, etc.)?
-

10) Women Only:

Are you pregnant or think you may be pregnant?
-

Due Date:
-

Are you nursing?
-

Are you taking oral contraceptives?
-

Dental History

When was your last dental visit?
-

Former Dentist:
-

Phone#:
-

Why are you here today?
-

Do you like your smile?
-

If you could, what would you change about your smile?
-

Please check any of the following that may apply to your dental health:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ clenching or Grinding
- ☐ Clicking or Popping Jaw
- ☐ Dentures or Partials (false teeth)

If so, how old are they?
-

- ☐ Difficulty in opening or closing jaw
- ☐ _Excessive daytime sleepiness
- ☐ Frequent Headaches
- ☐ Obstructive sleep apnea
- ☐ Orthodontics (braces)

Ifso, when?
-

- ☐ Receding Gums
- ☐ sensitivity to Cold
- ☐ sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ sensitivity to Bite
- ☐ snoring
- ☐ sores or Lumps in or near your mouth
- ☐ Trouble sleeping or staying asleep
- ☐ Other:

-

Have you ever had unusual reactions to dental treatments?
-

If yes, please explain:
-

Surveillance

I understand this premises is under surveillance.

Patient or Guardian Initials:
-

Consent for Services

I certify that I have read and understand the above. The above answers and information provided are true and correct. I understand that providing incorrect information can be harmful to my health. If I ever have any change in my health, I will inform the doctors at the next appointment. Radiographs in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination radiographs are generally taken once a year for adults and every six months for children. However, the frequency at which radiographs are taken will be based upon individual dental need. I authorize and consent the dentist to perform any and all forms of treatment including diagnostic aids, photos and radiographs, medication and therapy that may be indicated in connection with the patient as she deems fit. I authorize and request my insurance company to pay directly to Sincere Smiles otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my

dependent. I authorize Sincere Smiles to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists' providers which are assigned to me according to my insurance policy rule. It is Sincere Smiles procedure to share protected health information with labs, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary protected health information.

Patient or Guardian Initials:
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Financial Policy

Financial & Insurance Policies:
At Sincere Smiles our goal is to provide our patients with leading edge dental technologies, the finest dental materials, and expert staff in a comfortable environment. In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment (estimated co-pay, deductible, laboratory fees...) at the time of their visit. As a courtesy to our patients, we will file your dental claims and bill your dental insurance company(s) for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to vou.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1 ½ % (18% annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any accounts past due over 90 days may be sent to a collection agency. The fee estimate listed for dental care can only be extended for a period of three months from the date of patient examination.

Office Cancellation/Missed Appointment Policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice (two business days) if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee $75-150/hour (Appointments with our hygienists are $75/hour & Doctors $150/hour).

I have read the above policies and agree to their content.

Patient or Guardian Initials:
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DMFS & HIPAA

Proposition 65 M Dental Materials Fact Sheet (DMFS)

The state of CA, under the proposition 65, now requires each dentist to give each of their patients a copy of their information relating to the matters and techniques used in the dental environment. This information is contained in the attached document entitled "DENTAL MATERIAL FACT SHEET". It is required that all patients sign they have received a copy of this document. If you have any questions regarding information contained within the document, please feel free to bring your questions to our attention.

I acknowledge that I have received a copy of the DMFS required by law (forms received and signed prior to this form).

Patient or Guardian Initials:
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Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I acknowledge that I have received a copy of the HIPAA privacy practices (forms received and signed prior to this form).

Patient or Guardian Initials:
-

E-Signature Patient or Guardian (draw, upload or type) (ESign)

Date :