EVERY smile
FAMILY DENTISTRY + ORTHODONTICS

PATIENT INFORMATION

Patient Name ____________________________Preferred Name ___________________ Male _____ Female _______
Married Y/N ________Date of Birth ___________ Age _____Soc. Sec. #: ______________ Drivers Lic #: ___________
Spouse/Significant Other name: ____ Phone _________________________
Children/Siblings residing with you ____
Street Address ____ City____________ State _____Zip________
Home Phone # ______________________________ Work Phone # __________________________ Ext
Cell Phone # ______________________________ E-mail Address ____
Preferred contact method (circle) Home Phone Cell Phone Work Phone Email Text Message
Employer/School ____Occupation/Department ___________________
Full Time _________Part Time__________
Employer Address: ____City ____________ State _____Zip________
Emergency Contact (not living with you) __________________________________Phone _________________________

How did you hear about our office? _____________________

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _______________________________

BILLING INFORMATION

(Circle) Self Spouse Parent

Name ____ Date of Birth_______________ Age ______
Street Address____City _____________ State ___ Zip
Home Phone #_____________________________ Work Phone # ___________________________ Ext __
Cell Phone # ______________ E-mail Address ______________________________ Soc. Sec. #: ______
Employer ____Occupation ____________________
Employer Address: ____ City_____________ State ____ Zip

PRIMARY DENTAL INSURANCE

Subscriber Name _______________________________
Relationship to Patient ___________________________
Subscribers Date of Birth _________________________
Subscribers SS/ID#______________________________
Address (if different from patient)
____
Subscribers Employer______________________________
Insurance Company ____________________
Group #_______________________________________

SECONDARY DENTAL INSURANCE

Subscriber Name _______________________________
Relationship to Patient ___________________________
Subscribers Date of Birth _________________________
Subscribers SS/ID#______________________________
Address (if different from patient)
____
Subscribers Employer______________________________
Insurance Company ____________________
Group #_______________________________________

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Name: ______________________________ DOB: ___________ Phone #: __________________

Address: ____

Insurance changes ☐Yes ☐No

Anxiety level to Dentistry (1=low, 10=high) _________ Need of Pre-Med ☐Yes ☐No

Please indicate if you have an **ALLERGY** or **RATHER NOT TAKE** the following:

☐ Tylenol ☐ Penicillin or Amoxicillin ☐ NSAIDS ☐ Steroid therapy
☐ Clindamycin ☐ Sulfa ☐ Latex ☐ Dental Anesthetics
☐ Narcotics ☐ Codeine ☐ Fluoride
☐ Other_________________________________

Please indicate if any of the following applies to you:

☐ Artificial Joints/ Heart Valves	☐ Osteoporosis Treatment	☐ Immunosuppressant
☐ C-diff or gut issues in the past	☐ Drug/Alcohol Abuse Treatment	☐ Anxiety
☐ Heart Attack	☐ Diabetes (A1C_________)	☐ Epilepsy / Seizures
☐ High Blood Pressure	☐ HIV/ infectious disease	☐ Tobacco Use
☐ Pacemaker	☐ Radiation/Cancer Treatment	☐ Smoker/ E-Cigarettes/Vape
☐ Excess Bleeding	☐ Hepatitis	☐ Marijuana use
☐ Blood Thinner Medication	☐ Respiratory Problems _____________	☐ Liver Disease
☐ Fainting Spells/ Dizziness	☐ Frequent Sinus Problems	☐ Infectious Disease
☐ Antibiotics required for dental appointments	☐ Bisphosphonate medication/Bone Therapy (Fosamax, Boniva, Actonel, etc.)	☐ Surgery/ Hospitalization in past 2 years
☐ Pregnant/ Nursing	☐ Sleep Apnea / Snore	☐ Current/past drug or alcohol abuse

Other Conditions, diseases, etc. not listed above __________________________

Please list any medications that you are currently taking:

Medication Name:	Purpose:	Medication name:	Purpose:
______________________	______________________	______________________	____________________
______________________	______________________	______________________	____________________
______________________	______________________	______________________	____________________
______________________	______________________	______________________	____________________

Patient Signature _________________________________ Date: __________

Dentist Signature _________________________________ Date: ___________

Updates to **Medical History & Insurance Information** (Initial/Date)

Updated #1_______/_______ Updated #2 _______/_______Updated #3 ______/______ Updated #4______/______

Provider #1_______________ Provider #2_______________Provider #3_____________ Provider #4_____________

EVERY SMILE CHANDLER: NEW PATIENT DENTAL HISTORY

Name: ____ Date: _________ Preferred Name: ______________

Referred By: _________________________________ Previous Dentist: ____________________________________

Date of most recent dental exam: ________________ Date of most recent dental cleaning: ___________________

I routinely see my dentist every: ☐ 3months ☐ 6 months ☐12 months+ ☐ Only when I have something wrong

PERSONAL HISTORY	
Scale of 1-10, how fearful are you of dental treatment? (1= none, 10= high anxiety)	
Have you had an unfavorable dental experience of complications in the past?	□Y □N
Did you ever have braces or orthodontic treatment?	□Y □N

DENTAL AESTHETICS	
Is there anything about the appearance of your teeth that you would like to change?	
Would you like to someday whiten your teeth?	□Y □N
Do you have crowding/crooked teeth or spaces you are unhappy with?	□Y □N
Have you noticed any dark lines near the gumline of your current crowns?	□Y □N
Would you like bigger or different shaped teeth?	□Y □N
Have you been disappointed with the appearance of previous dental work?	□Y □N
Do you feel like you show too much gum when smiling?	□Y □N

GUM AND BONE	
How often (honestly) do you brush and floss?	
Do your gums bleed or are they painful when brushing or flossing?	□Y □N
Have you been treated for gum disease or been told you have lost bone around your teeth?	□Y □N
Have you ever noticed an unpleasant taste or odor in your mouth?	□Y □N

TOOTH STRUCTURE	
Have you had any cavities within the past 3 years?	□Y □N
Do you frequently experience dry mouth (cotton mouth)?	□Y □N
Do you have any missing teeth/spaces you would wish to fill with a replacement tooth?	□Y □N
Are any teeth sensitive to hot, cold, biting, or sweets?	□Y □N
Do you have notches near the gum line or holes on the biting surface of your teeth?	□Y □N
Do you frequently get food caught between any teeth?	□Y □N

BITE AND JAW JOINT	
Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)	□Y □N
Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	□Y □N
Do you chew ice, bite your nails, use your teeth to hold objects, or any other oral habits?	□Y □N
Do you clench or grind your teeth?	□Y □N
Do you snore or have restless sleep?	□Y □N

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APPOINTMENT GUIDELINES

We believe in the value of clear communication, as well as mutual understanding and respect prior to treatment rendered. It is our desire to provide high-quality dental care and individual attention for you in a timely manner. Your appointment time has been reserved especially for you and we make every effort to remind patients of their appointment as a courtesy. Therefore, if you break an appointment without 2 business days notice, we do not have sufficient amount of time to rebook another patient in need of treatment. With this in mind, a **$50.00 fee may be subject to the second missed appointment or cancellation less than 2 business days from your scheduled time.** This fee must be paid in full prior to any further appointment(s) scheduled.

(Initial) ________________

FINANCIAL & DENTAL INSURANCE GUIDELINES

Any monies due directly from the patient for services rendered are due **in full at the time of service** unless other arrangements are made in advance. We accept all major debit/credit cards, cash and checks. There will be a **$35.00 service charge** on all returned checks.

Understanding Dental Insurance is complicated for both the insured and the Doctor. When a patient gives us an insurance card, we call the insurance company to get your benefit information-usually in the form of a fax which contains basic benefit coverage.

When we put together a treatment plan for needed dental work diagnosed by the Doctor, we are basing the patient portion off the information provided by your insurance company. As a courtesy to our patients, we will collect your estimated co-pay in full at the time of service and bill the insurance directly for their estimated portion of treatment. If the insurance has not made their payment after 30 days of the claim being sent, we will supply the patient or guarantor with everything needed to contact their insurance in order to follow-up on their dental claim.

It is the mission of Dr. Lee and every staff member that from the moment you step through our front door, you have the best dental experience possible. In order to achieve this, your help is required.

We are asking for everyone to help and make sure their treatment is paid for in a timely fashion.

ANY BALANCE DUE AFTER 60 DAYS IS PAYABLE IN FULL FROM THE PATIENT WITHIN 10 DAYS OF NOTICE. Patient is responsible for any collection's fees, attorney fees, and court costs that could/will be accrued for any outstanding balances.

______________________________ ______________________________

Signature Date

AUTHORIZATION FOR SIGNATURE ON FILE

I ____________________________________ hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. This "signature on file" will be valid from the date signed. A photocopy of this document may act as an original

______________________________ ______________________________

Signature Date

How Your Health Information May Be Used (HIPPA)

To Provide Treatment

We will use your HEALTH INFORMATION within our officer to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentist, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

In Patient Reminders

We will remind you of any scheduled appointments or when it is time for you to make an appointment. We may also contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgement, when we believe we are specifically require to authorized by law or with the patient's agreement.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your ho9me hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want, we will use our very best judgement when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State, or Local law require us, we will not disclose your health information other that with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

List Patients Names:

____

____

____

____

Thank you for taking the time to review how we carefully use your health information. If you have any questions, we want to hear from you. If not, we appreciate your acknowledging your understanding of our policy by signing below.

Signature: ________________________

Relationship to patient: _______________

Date: ________________