564 Old York Road
Etters, PA 17319
Phone: (717) 938-1811
Fax: (717) 938-1815
contact@welovebeautifulsmiles.com
www.welovebeautifulsmiles.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name____ Last Name____ MI____ Preferred____

Home Address: ____ City:____ State:____ Zip:____

Date of Birth ____/____/____ SSN____-____-____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please provide at least 2 phone numbers in the event of an emergency or office closure.

Cell Phone:____ Home Phone:____ Work Phone:____

Email:____

PARENT/LEGAL GUARDIAN INFORMATION

First Name____ Last Name____ MI____ Preferred____

Date of Birth ____/____/____ SSN____-____-____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: ____ City:____ State:____ Zip:____

Please provide at least 2 phone numbers in the event of an emergency or office closure.

Cell Phone:____ Home Phone:____ Work Phone:____

Email:____

INSURANCE INFORMATION

Primary Dental Insurance

Subscriber Name:____

Date of Birth: ____/____/____ SSN:____-____-____

Insurance Company:____

Insurance Phone #:____

Group/Employer Name: ____

Member ID #:____ Group #:____

Secondary Dental Insurance

Subscriber Name:____

Date of Birth: ____/____/____ SSN:____-____-____

Insurance Company:____

Insurance Phone #:____

Group/Employer Name: ____

Member ID #:____ Group #:____

Medical Insurance (*Only for Federal Employees*)

Subscriber Name:____

Insurance Company:____

Group/Employer Name: ____

Date of Birth: ____/____/____ SSN:____-____-____

Insurance Phone #:____

Member ID #:____ Group #:____

EMERGENCY CONTACT

First Name____ Last Name____ MI____ Relationship____

Primary Phone Number____ Secondary Phone Number____

How did you hear about our office? ☐ Sign Out Front ☐ Google Review ☐ Mail/Flyer ☐ Facebook ☐ Other____

What made you choose our office? ____

Do you have a family member that comes here? ☐ YES ☐ NO Name:____ Relationship:____

Who may we thank for referring you? ☐ Patient ____ ☐ Other ____

Beautiful Smiles Family Dental Center
Medical & Dental History

Patient Name: _____ Date: _____

How would you rate your overall health? ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician Name: _____ **Phone #**: _____

Date of last physical examination: _____

Physician Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ **Phone #**: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Any serious illness, operations, or been hospitalized within the past 5 yrs? ☐ Yes ☐ No

If yes, for what reason? _____

Have you had any cosmetic procedures or elective surgeries completed? ☐ Yes ☐ No

If yes, please describe: _____ Treating Physician: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Have you had medical x-rays in the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Do you take any medications or supplements? ☐ Yes ☐ No

	Name	**Dose**	**Frequency**	**Reason**
Prescribed:				
Over Counter:				
Supplements:				

Do you take aspirin on a daily basis? ☐ Yes ☐ No

Have you been told to take antibiotics prior to any dental work? ☐ Yes ☐ No

If yes, for what reason? _____

Do you use tobacco? ☐ Yes ☐ No **Do you vape?** ☐ Yes ☐ No

Do you use marijuana? ☐ Yes ☐ No **Have you been prescribed a medical marijuana card?** ☐ Yes ☐ No

If yes, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not Interested in quitting

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how many on average per week? ☐ <1 drink ☐ 2-4 drinks ☐ > 5 drinks

Do you, or have you used recreational or street drugs? ☐ Yes ☐ No

If yes, how often? _____

_____ _____

Reviewing Doctor's Initials **Date**

Beautiful Smiles Family Dental Center
Medical & Dental History

Patient Name:_____ Date:_____

(Women ONLY)

Are you pregnant?	□ Yes	□ No
Are you looking to become pregnant?	□ Yes	□ No
Are you nursing?	□ Yes	□ No
Are you using a contraceptive?	□ Yes	□ No

If yes, initial the following statement: I understand that taking antibiotics may render contraceptives ineffective. _____

Check any of the following conditions you currently have or have had in the past:

Cardiovascular Conditions **If none of these apply check:** □ **NONE**

□ Angina □ Congenital Defect □ Irregular Heartbeat
□ Arteriosclerosis □ Damaged Heart Valves □ Mitral Valve Prolapsed
□ Artificial Valves □ Heart Attack □ Pacemaker
□ Chest Pain Upon Exertion □ Heart Murmur □ Rheumatic Heart Disease
□ Congenital Heart Failure □ Heart Surgery □ Scarlet Fever
□ Coronary Artery Disease □ High Blood Pressure □ Stroke
□ Other (please specify): _____

Respiratory Conditions **If none of these apply check here:** □ **NONE**

□ Asthma □ Hay Fever □ Sinus Problems
□ Bronchitis □ Persistent Cough/Produces Blood □ Tuberculosis (TB)
□ Emphysema □ Shortness of Breath
□ Other (please specify): _____

Blood Disorders **If none of these apply check here:** □ **NONE**

□ Abnormal Bleeding □ Bruise Easily □ Leukemia
□ Anemia □ Excessive Bleeding □ Sickle Cell Disease
□ Blood Transfusion □ Hemophilia
□ Other (please specify: _____

Psychological Conditions **If none of these apply check here:** □ **NONE**

□ Anxiety □ Depression □ Nervousness □ Psychiatric Treatment
□ Other (please specify): _____

Liver Conditions **If none of these apply check here:** □ **NONE**

□ Cirrhosis/Liver Disease □ Hepatitis □ Jaundice
□ Other (please specify): _____

Other Health Conditions **If none of these apply check here:** □ **NONE**

□ Allergies or Hives	□ Cortisone Medication	□ Herpes	□ Rheumatism
□ Arthritis	□ Diabetes	□ HIV Antibody/AIDS	□ STD
□ Artificial joint	□ Drug Addiction	□ Kidney Disease/Dialysis	□ Stomach Problems
□ Cancer	□ Epilepsy or Seizures	□ Measles	□ Thyroid disease
□ Chemotherapy	□ Fainting or Dizzy Spells	□ Mumps	□ Tumor
□ Cold Sores/Fever Blisters	□ Glaucoma	□ Radiation Treatment	□ Ulcers

_____ _____

Reviewing Doctor's Initials **Date**

Beautiful Smiles Family Dental Center
Medical & Dental History

Patient Name: _____ Date: _____

ALLERGIES

If none of these apply check here: ☐ **NONE**

Type	**Reaction (i.e. itching, rash, swelling of hands, eyes, or feet)**
☐ Aspirin	
☐ Codeine	
☐ Drugs/Other Medications	
☐ Foods	
☐ Jewelry	
☐ Latex/Rubber	
☐ Metals	
☐ Penicillin	

Do you have any disease, condition, or problem that was not previously listed? ☐ Yes ☐ No

If yes, please describe here: _____

When you walk up stairs or take a walk, do you ever have to stop because of chest pain? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than 2 pillows to sleep? ☐ Yes ☐ No

Do you wake up short of breath? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

If yes, please describe here: _____

To the best of my knowledge all of the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to **all** appointments.

Patient Name (Printed)	**Patient/Parent/Guardian (Signature)**	**Date**

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Beautiful Smiles Family Dental Center
Medical & Dental History

Patient Name:_____ Date:_____

DENTAL HEALTH SURVEY

History

How long has it been since your last dental appointment? □ <6 months □ 6-12 months □ 1-3 years □ > 5 years
Why did you leave your last dentist?_____

Have you ever had an injury to your face or jaw? □ Yes □ No
Do you have or have you had ***pain or discomfort*** in the mouth, face, jaws or jaw joints? □ Yes □ No
Have you had any complications with dental treatment? □ Yes □ No

Oral Hygiene Care

How often do you brush your teeth? □ 2 times/day □ 1 times/day □ 2-3 times/week

How often do you floss your teeth? □ 2 times/day □ 1 times/day □ 2-3 times/week

Do you have a power toothbrush? □ Yes □ No

If yes, what kind?_____

Do your gums bleed at any time? □ Yes □ No

Do you have aching or sensitive teeth? □ Yes □ No

Dental Concerns

If you could change one thing about your smile what would it be?_____

Which of the following would you like to discuss?

□ Existing discomfort □ Teeth whitening □ Mouth odor
□ Replacing old mercury silver filling □ Appearance of your smile
□ Recurring or untreated gum disease □ Prevention of decay
Other: _____

Do you snore or have you been told that you snore? □ Yes □ No
Would you like to have better quality sleep? □ Yes □ No
Do you suffer from dental anxiety? □ Yes □ No

If yes, please check the level of fear you have about your dental visits (10 being the greatest fear)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Are you interested in learning more about having anesthesia with your dental treatment? □ Yes □ No

Beautiful Smiles Family Dental Center
Authorization and Consent to Appointment and Financial Policies

Patient Name: _____ Date: _____

APPOINTMENT POLICY

Appointments are time specifically reserved with our providers for you. If you must change an appointment, please provide us at least **2 business days notice** so that we may use our time to accommodate other patients. **Late cancellations or no-show appointments will result in a charge assessed to your account. A $75 will be applied for the first hour with a subsequent charge of $50 for each additional hour.** Appointments 90 minutes or greater in length will require a $75 deposit. If you fail to provide the requested notice, your deposit will be retained and applied to the broken appointment fee. Another deposit will be required to reschedule the appointment. Anesthesia cases require a deposit equal to the estimated anesthesia cost, in order to reserve the appointment. **Failure to provide a cancellation notice of 3 business days will result in forfeiting the entire deposit.** If you cancel or fail to show for three (3) or more appointments within a one (1) year period we may terminate our professional relationship with you. Arriving 15 minutes, or more, late to your appointment may result in a broken appointment. After hours/weekend visits will result in a $250 fee for existing patients and $350 fee for new patients, which must be paid at the time of scheduling.
Parents are asked to remain in the waiting room during your child's appointment unless invited into the operatory by the doctor.

FINANCIAL POLICY

Estimated Co-Payments/Insurance:

Each new patient will have their insurance planned verified by a member of the business team to ensure you are eligible and your plan is active. It is your responsibility to notify our office of any changes to your insurance plan or coverage. Estimated co-pays are collected at the time of service. We do our very best to estimate your co-pay with accuracy, but due to ever-changing insurance plan provisions and limitations, we cannot guarantee coverage and/or exact payment from your insurance company for services rendered. All patients insured or uninsured accept financial responsibility for all services rendered at Beautiful Smiles Family Dental Center.

Payment Options and Finance Charges/Fees:

For your convenience we accept Cash, Visa, MasterCard, Discover and American Express. We work with Care Credit, a financing program that offers monthly payment options. No post-dated checks will be accepted nor can we accept personal checks until you are an established patient of the practice.
Balances in excess of 30 days are subject to a finance charge of 1.5% per month (18% annual). Balances in excess of 60 days will be considered delinquent and those over 90-days are subject to being turned over to collections. Any returned checks will result in a $35 fee assessed to your account.

AUTHORIZATION AND CONSENT

I acknowledge that I have read and understand the preceding policies and that I may request a copy of this agreement. By signing this form, I acknowledge that Beautiful Smile Family Dental Center may change any or all of the policies as outlined above without written notice to me. I agree to pay for all services rendered by this office. I authorize and request my insurance company to pay my benefits directly to Beautiful Smiles Family Dental Center. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered at this office and that I will be responsible for any expenses associated with such action. I agree and consent to a dental examination by Dr. Graver or Associate Doctor(s). I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I also, authorize Beautiful Smiles Family Dental Center to release any information regarding my medical/dental history, diagnosis or treatment to third party payers and/or other health professionals.

_____	_____	_____
Patient Name (Printed)	**Guarantor/Responsible Party (Signature)**	**Date**

This Agreement and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures appearing on this Agreement or such other documents are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Beautiful Smiles Family Dental Center
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ Date:_____

I,_____, have been informed of the office's Privacy Practices and Patient Bill of Rights
Print Full Name of Patient/Parent/Legal Guardian and understand I may request a printed copy if desired.

I authorize Beautiful Smiles Family Dental Center to speak with the following individual(s) about the full extent of my dental treatment, financial records, insurance policy and appointment scheduled:

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

This agreement is valid for the duration of my treatment at Beautiful Smiles Family Dental Center. You have the right to refuse signing this acknowledgement. I understand that I have the right to revoke this consent to release protected health information. A written, signed, and dated notice revoking the authorization must be submitted to the office to initiate the request.

Patient Name (Printed)	**Patient/Parent/Guardian (Signature)**	**Date**

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I give my consent to the doctors, clinical and business teams of Beautiful Smiles Family Dental Center to leave detailed messages or discuss scheduling, treatment, finances, surgery and any other information regarding my care, account, or insurance as follows:

___ Voice messages on cell phone or home phone number
___ Voice messages at work phone number
___ E-mail
___ I do not consent to detailed messages being left at my home, work, email, or cell phone.

Patient Name (Printed)	**Patient/Parent/Guardian (Signature)**	**Date**

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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 acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other (please specify)

Beautiful Smiles Family Dental Center
Consent for Radiographs, Fluoride & Pediatric Policy

Patient Name:_____ Date:_____

CONSENT FOR RADIOGRAPHIC IMAGES FOR DETECTION OF CARIES(CAVITIES)

I, _____, understand that annual radiographic images are
Print Full Name of Patient/Parent/Legal Guardian
required for proper diagnosing of caries/cavities. It has been explained to me that not all caries/cavities can be seen visually and that many are interproximal (between the teeth) and the only way to detect them is through the use of radiographic images. I further understand that if the patient is unable to complete intraoral radiographic images then extra-oral radiographic images will be taken. It is understood that not all insurance policies cover radiographic images at 100%, annually, or even at all; insurance carriers may apply an annual deductible to radiographic images. I understand that I will be responsible to cover the cost of the radiographic images, at the time services are rendered, or when a statement has been issued by Beautiful Smiles Family Dental Center. It is the policy of Beautiful Smiles Family Dental Center that all patients age four (4) years or older receive annual radiographic images, or at the patient's fourth visit with Beautiful Smiles Family Dental Center, whichever comes first. No school forms or oral health clearances (military, church missions, etc.) will be completed or signed by the doctors/staff of Beautiful Smiles Family Dental Center without the completion of diagnostic radiographic images.

Patient Name (Printed)	Patient/Parent/Guardian (Signature)	Date

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CONSENT FOR FLUORIDE TREATMENT

I, _____, consent to having fluoride treatment during my preventive care appointments.
Print Full Name of Patient/Parent/Legal Guardian
Fluoride varnish is a dental treatment that can help prevent tooth decay, slow it down, or stop it. I understand that fluoride treatment cannot completely prevent cavities. Dental caries is the most common chronic disease in children and adolescents, but we know that it's not just young people who are affected. With 9 in 10 American adults ages 20 to 64 years-of-age affected by dental caries, and a prevalence of 96% among older adults, dental caries is clearly a problem that affects all ages. I understand that my insurance may not cover the cost of fluoride treatment and acknowledge that by consenting to treatment I will be responsible for payment at the time of service.

Patient Name (Printed)	Patient/Parent/Guardian (Signature)	Date

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PARENTAL/LEGAL GUARDIAN ABSENCE IN THE DENTAL OPERATORY

I _____ understand that it is the policy of Beautiful Smiles Family Dental Center that
Print Full Name of Patient/Parent/Legal Guardian
prior to any treatment being performed on myself/ family member, all my questions and concerns will be answered. One parent/guardian will have the opportunity to walk with the patient to the assigned operatory and be present during the initial set-up of the planned procedure. Once it is time for treatment to begin, any person that has accompanied the patient will be escorted to the waiting room. I understand the need for providing the dentist and clinical team to have a space clear of distraction, and for my child(ren) to have direct focus on their provider, in order to provide safe and efficient treatment to the patient. I understand this consent is binding and will **ONLY** be revised if the request is made during the scheduling of the patient's appointment; no same day requests will be granted. Furthermore, I understand that all pediatric patients will be scheduled in the morning due to better behavior and cooperativeness seen typically during this time of day.

Patient Name (Printed)	Patient/Parent/Guardian (Signature)	Date

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