



NEW PATIENT PAPERWORK

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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
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: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Email: _____

INSURANCE INFORMATION

Primary Dental Insurance

Secondary Dental Insurance

Subscriber Name: _____
Date of Birth: ____/____/____ SSN: ____-____-____
Insurance Company: _____
Insurance Phone #: _____
Member ID #: _____ Group #: _____

Subscriber Name: _____
Date of Birth: ____/____/____ SSN: ____-____-____
Insurance Company: _____
Insurance Phone #: _____
Member ID #: _____ Group #: _____

EMERGENCY CONTACT

First Name _____ Last Name _____ MI _____ Relationship _____
Primary Phone Number _____ Secondary Phone Number _____

REFERRAL INFORMATION

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 can 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 being seen by your physician for any ongoing concerns/treatment?

Yes No

Do you have a primary care physician?

Yes No

Physician Name: _____

Phone #: _____

Physician Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of last physical examination: _____

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: _____ *Phone #:* _____

Have you had medical x-rays in the last 5 years?

Yes No

If yes, please explain: _____

MEDICATIONS & SUPPLEMENTS

IF NO MEDS/SUPPLEMENTS CHECK NONE: NONE

Name	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

IF NO ALLERGIES CHECK NONE: NONE

Type	Reaction (i.e. itching, rash, swelling of hands, eyes, or feet)
<input type="checkbox"/> Drugs/Other Medications	_____
<input type="checkbox"/> Foods	_____
<input type="checkbox"/> Metals	_____
<input type="checkbox"/> Other	_____

(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. _____

Reviewing Doctor's Signature

Date

**Beautiful Smiles Family Dental Center
Medical & Dental History**

Patient Name: _____

Date: _____

MEDICAL CONDITIONS

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

CARDIOVASCULAR CONDITIONS

If none of these apply check: NONE

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congenital Defect | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Damaged Heart Valves | <input type="checkbox"/> Mitral Valve Prolapsed |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest Pain Upon Exertion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Congenital Heart Failure | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other (please specify): _____ | | |

RESPIRATORY CONDITIONS

If none of these apply check: NONE

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Persistent Cough/Produces Blood | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Other (please specify): _____ | | |

BLOOD DISORDERS

If none of these apply check: NONE

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Other (please specify): _____ | | |

PSYCHOLOGICAL CONDITIONS

If none of these apply check: NONE

- | | | | |
|--|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Other (please specify): _____ | | | |

LIVER CONDITIONS

If none of these apply check: NONE

- | | | |
|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cirrhosis/Liver Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Other (please specify): _____ | | |

OTHER HEALTH CONDITIONS

If none of these apply check: NONE

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Antibody/AIDS | <input type="checkbox"/> STD |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Disease/Dialysis | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Other (please specify): _____ | | | |

Reviewing Doctor's Signature

Date

**Beautiful Smiles Family Dental Center
Medical & Dental History**

Patient Name: _____

Date: _____

Do you take aspirin daily? 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

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

Have you been prescribed a medical marijuana card? Yes No

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? _____

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 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: _____

MEDICAL HISTORY ACKNOWLEDGEMENT

To the best of my knowledge all 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

Reviewing Doctor's Signature

Date Page 4

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 1-4 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

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
- Bad Breath
- Replacing Silver Filling(s)
- 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

Reviewing Doctor's Signature

Date

**Beautiful Smiles Family Dental Center
Acknowledgement and Consents**

Patient Name: _____

Date: _____

APPOINTMENT POLICY

Appointments are specifically reserved with our providers for you. If you must change an appointment, please provide us with 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 fee of \$75 is assessed for the first hour with a prorated charge for appointments more than one hour in length.** 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 to schedule, equal to the estimated anesthesia cost. **Failure to provide 3 business days' notice to cancel or reschedule an anesthesia appointment will result in forfeiting the entire deposit.** If you cancel or fail to show 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 for your appointment may result in a broken appointment. After hours and weekend appointments will result in a \$250 fee for existing patients and \$350 fee for new patients. Parents are asked to remain in the waiting room during their child's appointment unless invited into the operatory by the doctor.

FINANCIAL POLICY

Co-Payments & Insurance:

If you have dental insurance, our office staff will assist you by submitting insurance claims and verifying your benefits for services. An estimate can be provided to you upon request in advance of any appointment. ALL estimated out-of-pocket totals are due **on or before** your scheduled appointment, unless other financial arrangements have been made with the Office Manager in advance of your appointment. ***Please be advised that although our office will make every effort to accurately estimate what your insurance will pay, this does not, in any way, guarantee actual payment from your insurance company.*** Regardless of any anticipated plan coverage, you assume full financial responsibility for any services rendered at Beautiful Smiles Family Dental Center. Uninsured patients and those with out-of-network plans are responsible for payment in full at the time of service.

Payment Options and Finance Charges/Fees:

For your convenience we accept Cash, Visa, MasterCard, Discover and American Express. We also offer Care Credit, a financing program that offers monthly payment options. No personal checks will be accepted. Balances of more than 30 days are subject to a finance charge of 1.5% per month (18% annual). Balances more than 60 days will be considered delinquent. Returned checks are subject to a \$35 fee.

AUTHORIZATION AND CONSENT

I acknowledge that I have read and understand the preceding policies and that I may request a copy of the policy. By signing this form, I acknowledge that Beautiful Smile Family Dental Center (BSFDC) may change any or all the policies as outlined above with or without notice. I agree to pay for all services rendered by this office. I authorize and request my insurance company to pay my benefits directly to BSFDC. I understand that some insurance companies will not remit payment to the provider and that any payment/benefit checks issued to the subscriber are due to the office. I also understand that should my account become delinquent, my information may be released to CBY Professional Services (CBY) 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. By signing below, I agree to receive calls, text messages, and emails from CBY and its partners. These messages may contain details about products, services, and debt collection in case of unpaid bills. These messages may be sent using automatic systems or recorded voices. Standard message and data rates may apply. You can opt out at any time by contacting CBY at 717-843-8685. 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 BSFDC to release any information regarding my medical/dental history, diagnosis or treatment to third party payers and/or other health professionals.

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.

Responsible Party's Name (Printed)

Patient Signature (Parent/Guardian if under 18yrs)

Date

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

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

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)

