

PAPERWORK UPDATE FOR CURRENT PATIENTS

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: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Primary Phone Number: _____ Secondary Phone Number: _____

PHYSICIAN & PHARMACY

Physician Name: _____ Pharmacy Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Date of Last Physical: _____ Fax Number: _____

****** ONLY IF UNDER 18 YEARS OF AGE ******

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: _____

Phone: _____

MEDICAL HISTORY

How would you rate your overall health? Good Fair Poor

Are you currently under the care of a physician for an ongoing condition? Yes No

Any serious illness, operations, or been hospitalized within the past 5 years? 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? (CT Scan/MRI, etc.) 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	_____

Do you take aspirin daily? Yes No

Have you been told to take antibiotics prior to 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

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

If yes, how often? _____

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

Do you drink alcoholic beverages? Yes No

If Yes, How Many per Week? < 1 2-4 > 5

When using stairs or taking 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

Are you on a special diet? Yes No

If yes, please describe here: _____

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

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

If yes, please describe here: _____

*******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 taking contraceptive, initial the following statement:

I understand that taking antibiotics may render contraceptives ineffective. _____

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

Page 4/6

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.

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 (Print)

Patient Signature (Parent/Guardian if under 18yrs)

Date

Reviewing Doctor's Signature

Date

HIPAA/NOTICE OF PRIVACY PRACTICES

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: _____

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
- Text Messages
- E-mail
- I do not consent to detailed messages being left at my home, work, email, or cell phone.

This agreement is valid for the duration of my treatment at Beautiful Smiles Family Dental Center. You have the right to refuse to sign 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.

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.

Patient Name (Print)

Patient Signature (Parent/Guardian if under 18yrs)

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)

Reviewing Doctor's Signature

Date