

NEW PATIENT PAPERWORK

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

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

Secondary Dental Insurance

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)

☐ Drugs/Other Medications _____

☐ Foods _____

☐ Metals _____

☐ 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

- | | | |
|--|---|--|
| ☐ 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: ☐ 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: ☐ 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: ☐ NONE

- | | | | |
|--|-------------------------------------|--------------------------------------|--|
| ☐ Anxiety | ☐ Depression | ☐ Nervousness | ☐ Psychiatric Treatment |
| ☐ Other (please specify): _____ | | | |

LIVER CONDITIONS

If none of these apply check: ☐ NONE

- | | | |
|--|------------------------------------|-----------------------------------|
| ☐ Cirrhosis/Liver Disease | ☐ Hepatitis | ☐ Jaundice |
| ☐ Other (please specify): _____ | | |

OTHER HEALTH CONDITIONS

If none of these apply check: ☐ 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 |
| ☐ 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

**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 National Recovery Agency (NRA) 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 NRA 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 NRA at 800-360-9953. 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

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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)

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

Consent for Radiographic Images for Detection of Caries(Cavities)

I, _____, understand that annual radiographic images are required for proper
Print Full Name of Patient/Parent/Legal Guardian

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 with radiographic images. I understand that if the patient is unable to complete intraoral radiographic images then extraoral radiographic images will be taken. 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.

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 (Printed)

Patient/Parent/Guardian (Signature)

Date

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.

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 (Printed)

Patient/Parent/Guardian (Signature)

Date

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 to provide the dentist and clinical team with a space clear of distraction, and for my child(ren) to have direct focus on their provider(s) allowing for safe and efficient treatment. 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.

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 (Printed)

Parent/Guardian (Signature)

Date