

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)**

- ☐ Drugs/Other Medications _____
- ☐ Foods _____
- ☐ Metals _____
- ☐ 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

- | | | |
|--|---|--|
| ☐ 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): _____ | | | |

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 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 (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