Smile Care Dental Associates

815-609-8588
www.smilecare-dental.com
Care that make Smiles grow

Thank you for choosing our healthcare team! We will strive to provide you with the best possible dental care.

To help us meet your entire dental healthcare needs, please fill out this form completely. Please print.

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle		Preferred Name / Nickname
Birthdate / /	Social Security Number	❑ Male ❑ Female	❑ Mr. ❑ Ms. ❑ Dr. ❑ Mrs.	❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Street Address				Home Phone ( )
City		State	Zip	Cell Phone ❑ ok to text reminders ( )
Email Address	Occupation	Employer		Work Phone ( )

How did you hear about our office? ❑ Family ❑ Friend/ Coworker ❑ Insurance Directory ❑ Internet/ Email ❑ Flyer/ Direct Mailing ❑ Outdoor Signs ❑ Marketing Representative

Whom may we thank for referring you to your practice?	Other Family Members Seen Here

INSURANCE

Person Responsible for Bill			Relationship to Patient
Birthdate / /	Social Security Number	Email Address	Home Phone ( )
Street Address (if different)			Cell Phone ( )
City	State	Zip	Work Phone ( )

Primary Insurance Company	Subscriber's Name	ID #	Group #
Secondary Insurance Company	Subscriber's Name	ID #	Group #

DENTAL HISTORY

Reason for Today's Visit ❑ Routine Exam/Cleaning ❑ Pain/Emergency ❑ Consultation ❑ Other_____

Are you in pain? ❑ Yes ❑ No If yes, how long?_____

Please indicate any of the following problems:

- ❑ Red, swollen or bleeding gums
- ❑ Sensitive teeth or gums
- ❑ Sensitive to heat
- ❑ Sensitive to cold
- ❑ Broken/chipped tooth
- ❑ Lost/broken filling(s)
- ❑ Teeth grinding
- ❑ Ringing in ear
- ❑ Bad breath
- ❑ Stained teeth
- ❑ Blisters/sores in or around the mouth
- ❑ Discomfort, clicking or popping in jaw

Do you require pre-medication (antibiotics prior to dental treatment)? ❑ Yes ❑ No ❑ Don't Know

Previous Dentist	City, State	Phone
Last Dental Visit	Last X-Rays	

Reasons for changing dentist: ❑ Moved ❑ Changed insurance ❑ Not satisfied with previous dentist ❑ Referred to our office ❑ Other_____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient
Home Phone ( )	Cell Phone ( )	Work Phone ( )

MEDICAL HISTORY

Name of Primary Physician	Physician's Phone ( )

Please indicate if you have or ever had any of the following diseases or medical conditions:

❑ Heart Attack / Stroke	❑ Stomach Problems / Ulcers	❑ Severe/Frequent Headaches
❑ Heart Surgery / Pacemaker	❑ Psychiatric Problems	❑ Frequent Neck Pain
❑ Heart Murmur	❑ Venereal Disease	❑ Shingles
❑ Rheumatic Fever	❑ Alcohol / Drug Abuse	❑ Asthma
❑ Mitral Valve Prolapse	❑ Tuberculosis (TB)	❑ Difficulty Breathing
❑ Artificial Valves	❑ Jaw Problems (TMJ / TMD)	❑ Diabetes
❑ Heart Disease	❑ Cancer / Tumor	❑ Anemia
❑ Congenital Heart Defect	❑ Chemotherapy / Radiation	❑ Low Blood Pressure
❑ Chest Pains	❑ Hepatitis	❑ High Blood Pressure
❑ Scarlet Fever	❑ HIV+ / AIDS	❑ Bleeding Problems
❑ Kidney Problems	❑ Arthritis / Rheumatism	❑ Glaucoma
❑ Liver Problems	❑ Artificial Bones / Joints	❑ Back Problems
❑ Respiratory Problems	❑ Emphysema	❑ Other Medical Conditions_____
❑ Sinus Problems	❑ Fainting / Seizures / Epilepsy	

Please list all medications you are currently taking:

Are you allergic to any of the following?

❑ Aspirin	❑ Penicillin	❑ Local Anesthetics
❑ Ibuprofen	❑ Codeine	❑ Other Medications_____
❑ Sulfa Drugs	❑ Latex	

Do you use tobacco?	❑ Yes	❑ No	If yes, what form?_____	How much?_____	How long?_____

For Women: Are you pregnant? ❑ Yes ❑ No If yes, how long?_____ | Are you nursing? ❑ Yes ❑ No

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize and give consent to perform any necessary or advisable services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Smile Care Dental Associates. I understand that I am financially responsible for any balance.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X _____

PATIENT/GUARDIAN SIGNATURE DATE