White Smiles
FAMILY DENTAL

New Patient Information

ABOUT YOU

First Name: _____ Middle Initial: _____ Last name:_____

Date of Birth: _____ Email address:_____

Social Security #: _____ Home phone: _____ Cell Phone:_____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address:_____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work phone: _____

Employer's Address: _____ City: _____ State:_____

Whom May We Thank for Referring You to Our Office?

Name: _____

Google/Internet/Other: _____

Emergency Contact Name: _____ Relationship: _____

Emergency contact phone number: _____

RESPONSIBLE PARTY (If different than yourself)

First Name: _____ Middle Initial: _____ Last name:_____

Birthdate: _____ Social Security Number: _____

Address: _____

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INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Insured Full Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security Number: _____

Occupation: _____ Employer's address: _____

Work Phone:_____

Insurance Company Name: _____

Insurance company address: _____

Insurance company phone number: _____

Policy Number: _____Group Number: _____

SECONDARY INSURANCE INFORMATION:

Insured Full Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security Number: _____

Occupation: _____ Employer's address: _____

Work Phone: _____

Insurance Company Name: _____

Insurance company address: _____

Insurance company phone number: _____

Policy Number: _____ Group Number: _____

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MEDICAL HISTORY

The following information is necessary to provide your dental care safely. We review your given medical history prior to providing dental treatment.

Current Physician: _____ Date of last examination: _____

Have you been hospitalized for serious illness in the last five years? □ YES □ NO

If yes, please explain: _____

Have you been treated with bisphosphonates for osteoporosis or cancer? □ YES □ NO

MEDICATION AND SUPPLEMENT LIST

Please list all medications you are taking. Include prescriptions, herbal supplements and any OTC meds	
1.	5.
2.	6.
3.	7.
4.	8.

Please list **ANY** and **ALL ALLERGIES** you may have and the **REACTION** it causes.

_____

_____

Do you smoke? □ YES □ NO If yes: Packs per day? _____ How long? _____

Do you chew tobacco? □ YES □ NO How long? _____

WOMEN: Are you currently Pregnant? □ YES □ NO

If Yes, Due date: _____

WOMEN: Are you currently nursing? □ YES □ NO

WOMEN: Are you currently taking oral contraceptives? □ YES □ NO

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Condition	Please Circle	Describe any "YES" in detail
AIDS/HIV Positive	YES NO	
Alcohol/chemical dependency	YES NO	
Aneurysm	YES NO	
Angina (Chest pain)	YES NO	
Arthritis/Rheumatism	YES NO	
Artificial Heart Valve	YES NO	
Artificial joint (knee, hip, shoulder, etc.)	YES NO	
Asthma	YES NO	
Bleeds Easily	YES NO	
Blood Thinners	YES NO	
Blood Transfusion	YES NO	
Bruise Easily	YES NO	
Cancer	YES NO	
Chemotherapy	YES NO	
Chronic (long-time) Cough	YES NO	
Clotting disorders	YES NO	
Cold Sores/Fever Blisters	YES NO	
Congenital Heart Disease	YES NO	
Diabetes	YES NO	
Embolism (Blood clot)	YES NO	
Emphysema	YES NO	
Epilepsy/Seizures	YES NO	
Fainting or Dizzy Spells	YES NO	
Glaucoma	YES NO	
Heart Surgery/Disease/Attack	YES NO	

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Heart Murmur	**YES**	**NO**	
Heart Pacemaker	**YES**	**NO**	
Hemophilia	**YES**	**NO**	
Hepatitis (A, B, C)	**YES**	**NO**	
High/low blood pressure	**YES**	**NO**	
Infective Endocarditis (infection of the heart)	**YES**	**NO**	
Kidney Trouble	**YES**	**NO**	
Latex Allergy	**YES**	**NO**	
Liver Disease/Problems	**YES**	**NO**	
Neurological disorders	**YES**	**NO**	
Nervous/Anxious	**YES**	**NO**	
Radiation Therapy	**YES**	**NO**	
Rheumatic fever/heart disease	**YES**	**NO**	
Sinus Trouble/Hay Fever	**YES**	**NO**	
Stroke/TIA	**YES**	**NO**	
Thyroid problems	**YES**	**NO**	
Tuberculosis	**YES**	**NO**	
Tumors	**YES**	**NO**	
Ulcers/Colitis	**YES**	**NO**	
Vertigo	**YES**	**NO**	

Other: Any Other condition not mentioned above: _____

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DENTAL HISTORY

What is your reason for today's visit? _____

How often do you brush? _____ How often do you floss? _____

Please circle any that may apply to you:

1. Do your gums bleed when you brush or floss?	**YES**	**NO**
2. Do you have sensitive teeth?	**YES**	**NO**
3. Are any of your teeth loose?	**YES**	**NO**
4. Do you have any broken teeth or fillings?	**YES**	**NO**
5. Do you have jaw pain?	**YES**	**NO**
6. Any injuries to teeth?	**YES**	**NO**
7. History of unpleasant dental experiences?	**YES**	**NO**
8. History of Orthodontics (braces, retainers, etc.)	**YES**	**NO**
9. History of Gum Treatments?	**YES**	**NO**
10. History of Implants?	**YES**	**NO**
11. History of Root canals?	**YES**	**NO**
12. History of Oral Surgery?	**YES**	**NO**
13. History of Crowns?	**YES**	**NO**
14. History of Veneers?	**YES**	**NO**
15. Are you happy with the appearance of your teeth?	**YES**	**NO**
16. Are you interested in whitening your teeth?	**YES**	**NO**
17. Are you interested in replacing any missing teeth?	**YES**	**NO**
18. Do you have any questions for Dr. Shannon or Dr. Preston?	**YES**	**NO**

HIPAA PATIENT CONSENT FORM

White Smiles Family Dental, LLC

Patient Consent for Use and Disclosure of Protected Health Information.

I hereby give my consent for **White Smiles Family Dental** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **White Smiles Family Dental** describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **White Smiles Family Dental** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **White Smiles Family Dental.**

With this consent, **White Smiles Family Dental** may call/contact my home and leave a message (to include but not limited to) an answering device, voice mail, text mail, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **White Smiles Family Dental** may mail/email/text to my home or other alternative location any items that may assist in the practice in carrying out TPO (to include but not limited to) such as appointment reminder cards and patient statements. I have the right to request **White Smiles Family Dental** restrict how it uses or discloses my PHI to carry out TPO. The practice it not required to agree to my requested restrictions but will do it's best to honor the request.

By signing this form, I consent to allow **White Smiles Family Dental** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **White Smiles Family Dental** may decline to provide treatment to me.

I authorize the release of my PHI for discussion of care, treatment, or payment to the person(s) specified below. This does not give these persons permission to make healthcare decisions for me.

Primary Contact (Other than patient): _____ Relationship: _____ Phone: _____

Secondary contact: _____ Relationship: _____Phone: _____

_____

Signature of patient or Legal Guardian:

_____ Date: _____

WOULD YOU LIKE A COPY OF THE OFFICE HIPAA PRIVACY FORM? □ YES □ NO

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FINANCIAL POLICY

We are happy you have chosen White Smiles Family Dental to serve your dental needs. Please take the time to read the following, initial each section, and sign and date the bottom of the form.

_____ Payment in full is due at the time of service **UNLESS** arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately **MY** obligation. We will file your primary and your secondary as a courtesy to you. However, insurance balances which are not paid within 90 days may be billed to you.

_____ Some of your treatment may NOT be covered by your insurance carrier. The cost which is not covered will be your responsibility.

_____ Patients are asked to cancel their appointments at least 48 hours in advance so we may reserve that time for someone else if you are unable to come. Repeated late cancellations/missed appointments may result in a $50.00 charge.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18 % APR collection fees (up to 25% of the full balance)
Legal fees for collection services

_____ _____

Signature of Patient or Guardian **Date**