Patient Information

Patient's Name (First and Last):_____ Date:_____

If child, parent's name:_____ Cell#:_____

Social Security # **(INS purposes only)**:_____ M/F DOB:_____

Home address:_____ 2nd Phone#:_____

Unit/Apt#:_____City:_____ State:_____ Zip Code:_____

Email Address:_____

Employer Name **(INS purposes only)**:_____ Student? [ ] Yes [ ] No

Emergency Contact Name:_____ Cell#_____

Do you have dental insurance? [ ] Yes [ ] No

-If yes, please complete the next section:

Ins Company_____ Member ID #:_____

Policy Holder Name:_____ DOB:_____

Reason for visit today:_____

How did you hear about our practice?

[ ] Flyer
[ ] Drive By
[[TV Commercial
[ ] Referred by _____
[ ] Google
[ ] Outreach/Marketing _____
[ ] Outside Professional Referral
[ ] Other _____

Please answer all of the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. ALL INFORMATION YOU PROVIDE WILL BE KEPT CONFIDENTIAL.

Please answer by circling Y or N for each individual question.

1. **Are you in good health?**.....Y N
2. **Has there been any change in your general health in the past year?**.....Y N
3. **Date of last check-up by physician**_____
4. **Are you currently under a physician's care?**.....Y N
   -If so, what for?_____
   Treating Physician's Name:_____ **Number:**_____
5. **Have you had any serious illness, operation or hospitalizations?**.....Y N
   If so, describe and give approximate dates: _____
   _____
   _____
6. **Have you ever had intravenous sedation or general anesthesia?**.....Y N
   Were there any adverse effects?.....Y N
7. **Do you generally tolerate dental treatment well?**.....Y N
8. **Do you have or have you ever had:**
   a. **Heart disease that was detected at birth**.....Y N
   b. **Rheumatic fever or rheumatic heart disease**.....Y N
   c. **Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)**.....Y N
   d. **Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)**.....Y N
   e. **Neurological disorders (seizure, epilepsy, fainting, dizziness)**.....Y N
   f. **Blood disease (bleeding disorder, anemia, transfusion, easily bruise)**.....Y N
   g. **Liver disease (jaundice, hepatitis)**.....Y N
   h. **Kidney disease**.....Y N
   i. **Diabetes**.....Y N
   j. **Thyroid disease**.....Y N
   k. **Arthritis? If so, which joints?**.....Y N
   l. **Stomach ulcers or intestinal problems**.....Y N
   m. **Glaucoma**.....Y N
   n. **Frequent or recurring mouth sores**.....Y N
   o. **Implants/artificial joints anywhere in your body? (heart valve, hip knee)** Y N
   p. **Radiation (x-ray treatment for cancer) in head/neck region?**.....Y N
   q. **Noises in jaw joint, pain near ear when chewing, grind or clench teeth?** Y N
   r. **Sinus or nasal problems**.....Y N
   s. **Any disease, drug, transplant operation or HIV that has depressed your immune system**.....Y N

9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING?

a. Antibiotics.....Y N
b. Anticoagulants (blood thinners).....Y N
c. Thyroid medications.....Y N
d. Antihistamines, decongestants.....Y N
e. High blood pressure meds.....Y N
f. Steroids.....Y N
g. Tranquilizers, antidepressants.....Y N
h. Stomach or GI medications (antacids, etc).....Y N
i. Cholesterol reducing drugs.....Y N
j. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers.....Y N
k. Weight reduction pills or diet aids (OTC or "natural" products).....Y N
l. Vitamins, natural remedies (ginko biloba, ephedra, ginseng, etc) or other supplements.....Y N
m. Marijuana, cocaine or other "recreational" drugs.....Y N
n. Any other medications, pills, supplements or drugs?.....Y N
Please list all current medications here:

_____

10. Are you allergic to or had a bad reaction from:

A. Local anesthetic (Novocain-like drugs) Y N
B. Penicillin, amoxicillin, cephalosporin? Y N
C. Other antibiotics?.....Y N
D. Barbiturates, sedatives?.....Y N
E. Aspirin, ibuprofen, NSAIDS or other Pain relievers?.....Y N
F. Codeine, narcotics, opioids Y N
G. Latex.....Y N
H. Other allergies or reactions Y N
Please list:_____
_____
_____

11. Do you have high fever, frequent skin rashes, etc?.....Y N
12. Do you use alcohol? How much per day?.....Y N
13. Do you smoke?.....Y N
What product and how many per day?.....For how long?.....
14. Do you spit tobacco?.....For how long?.....
15. Are you, or have you been, in drug or alcohol recovery program?.....Y N
16. Do you have any other disease, condition or problem not listed that you think the Dr. should know about?.....Y N
17. Do you wish to talk to the Dr privately about anything?.....Y N
18. Any additional comments?_____

WOMEN:

Are you taking birth control pills?.....Y N
Are you pregnant or trying to become pregnant?.....Y N
Are you breast feeding?.....Y N
Are you taking hormonal replacement?.....Y N

If you are a parent of the patient, please read and sign the next section:

I am the parent/guardian of _____ and there are no court orders in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

Signature:_____ Date:_____

If you have insurance, please read and sign the next section:

I certify that myself or my dependent(s) are covered by insurance with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my minor/child health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature:_____ Date:_____

If you are a cash patient, please read and sign the next section:

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges of services or items provided to me or the patient. I understand that filing a claim with my insurance company separately does not relieve me from my responsibility for the payment of all charges.

Signature:_____ Date:_____

HIPPA consent

I understand that under the Health Insurance Portability and Accountability Act of 1966 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in order to:

-Conduct my treatment and share information among multiple providers who may be involved in that treatment

-Obtain payment from third party payers

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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bonded to abide by such restrictions.

Signature:_____ Date:_____

iSmile Specialists
14121 Southwest Freeway #B
Sugar Land, TX 77478
281-4 iSmile

I, _____, consent to be a patient at iSmile Specialists and agree to a radiographic and clinical examination, I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a through and complete medical history, supply a full list of medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I will inform my dentist of any medical changes.

3. No guarantees can be made about treatment outcomes, restorative longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____	_____	_____
Parent or Guardian Name	Signature	Date
_____	_____	_____
Witness	Signature	Date

TREATMENT PLANNING/PERIODIC EXAM

NAME: _____

DATE _____ Initial / Recall / Consult

Account # / Plan _____

Medical Alert? _____

Chief Complaint _____

Head & Neck	WNL	Comments _____
Soft Tissue / Lymph Nodes	WNL	
Lips / Cheeks	WNL	
Hard & Soft Palate	WNL	
Floor of Mouth	WNL	
Tongue	WNL	Oral - CD Biopsy? Y N
Gingiva	WNL	

TMJ WNL

Comments _____

Nightguard Y N

Occlusal Adjustment Y N

Referral? Y N

ORTHODONTICS WNL refer?

Comments _____

PERIODONTAL ASSESSMENT

Plaque L M H

Calculus L M H

Oral Hygiene E G F P

Type O I II III IV

Future Perio Referral Likely? Y N Unsure

Other Description _____

FMX Full Perio Charting Prophy Fluoride OHI Quads S, RP, C UR UL LR LL Other _____ (gross scale: therapeutic: etc.) Other Adjunct _____ (irrigation: Arestin: Atridox, etc.)

TOOTH	EXISTING	REASON FOR TREATMENT	NEEDED TREATMENT	OPTIMAL TREATMENT/FUTURE	PRIORITY
1		refer?	1		
2			2		
3			3		
A 4			4		
B 5			5		
C 6			6		
D 7			7		
E 8			8		
F 9			9		
G 10			10		
H 11			11		
I 12			12		
J 13			13		
14			14		
15			15		
16		refer?	16		
17		refer?	17		
18			18		
19			19		
K 20			20		
L 21			21		
M 22			22		
N 23			23		
O 24			24		
P 25			25		
Q 26			26		
R 27			27		
S 28			28		
T 29			29		
30			30		
31			31		
32		refer?	32		

U REMOVABLE PROSTHETICS _____ Existing _____ Age _____ Treatment (include teeth & clasps) _____ Standard _____ Deliver

PROGRESS NOTES

Patient Name: Patient #:

Date Asst. Dentist	Weight & Blood Pressure	Treatment To Be Billed Please include Tooth # and Surface	Progress Notes