CHECK IN:

FINAL REVIEW:

BP ______

Although dental professionals primarily treat the area in your mouth, health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following confidential questions.

PATIENT INFORMATION

Patient Name ______ D.O.B ______ SSN ______ Date ______

Nickname ______ ○ Male ○ Female | ○ Single ○ Married ○ Divorced ○ Widowed ○ Partner

Your Address ______ City ______ St ______ Zip ______

Email ______ Home # ______ Cell # ______ Work # ______

Emergency Contact ______ Relationship ______ Phone ______

Are you a student? ○ Yes ○ No Where? ______ ○ Full Time ○ Part Time

Who can we thank for referring you? ______

DENTAL INSURANCE INFORMATION

Insured's Name ______ D.O.B ______ Relationship to Patient ______

Ins Company ______ Ins Phone ______ I.D # ______

Employer ______ Group Number ______ Insured's SSN ______

MEDICAL HEALTH

Physician ______ Phone ______ Last Physical Exam ______

General Health: ○ Excellent ○ Good ○ Fair ○ Poor

Have you had any serious illness, operation, complication, been hospitalized in the past 5 years? ○ Yes ○ No If yes, please explain:

______

Are you taking medication? If so, what? ______

______

Are you allergic to: ○ Penicillin ○ Latex ○ Local Anesthetics ○ Codeine ○ Sulfa ○ None

Any other allergies? ______

Do you have any dental concerns? ○ No ○ Yes, ______

Women: Are you pregnant or think you may be pregnant? ○ Yes ○ No Trimester? ○ 1 ○ 2 ○ 3 Nursing? ○ Yes ○ No

Indicate which of the following you have had or have at present. Fill in yes or no and circle options.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abnormal Bleeding	○ Yes	○ No	Head Injuries	○ Yes	○ No	Nervous Disorders	○ Yes	○ No
AIDS/HIV Positive	○ Yes	○ No	Hearing Impaired	○ Yes	○ No	Osteoporosis	○ Yes	○ No
Alzheimer's/Dementia	○ Yes	○ No	Heart Disease	○ Yes	○ No	Bisphosphonates*	○ Yes	○ No
Anemia	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No	*IV/Oral?		
Arthritis/Rheumatoid	○ Yes	○ No	Heart Stent/Shunt	○ Yes	○ No	Parkinson's Disease	○ Yes	○ No
Asthma	○ Yes	○ No	Heart Valve Replacement	○ Yes	○ No	Prosthetic Joints*	○ Yes	○ No
Blood Disease	○ Yes	○ No	Hepatitis*	○ Yes	○ No	*Where/When?		
Blood Thinners	○ Yes	○ No	*Circle Type: A, B, C, D, E, F, G			Raditation Treatment	○ Yes	○ No
Cancer	○ Yes	○ No	Herpes	○ Yes	○ No	Sinus Problems	○ Yes	○ No
Chemotheraphy	○ Yes	○ No	High or Low Blood Pressure	○ Yes	○ No	Smoke/Chew Tobacco	○ Yes	○ No
Convulsions/Seizures	○ Yes	○ No	Infective Endocarditis	○ Yes	○ No	Sleep Apnea/CPAP	○ Yes	○ No
Digestive Disease	○ Yes	○ No	Kidney Disease	○ Yes	○ No	Steroid Use	○ Yes	○ No
Diabetes Type 1 or 2	○ Yes	○ No	Mitral Valve Prolapse	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Excessive Bleeding	○ Yes	○ No	Multiple Sclerosis	○ Yes	○ No	Ulcers	○ Yes	○ No
Epilepsy	○ Yes	○ No	Neck/Back Problems	○ Yes	○ No	Vape Smoker	○ Yes	○ No

Other ______

***For parents of minors: By signing below, you are agreeing to be responsible guardian for the minor's account and balances.**

Patient/Guardian Signature	Date	Doctor Signature	Date

YOUR DENTAL STORY

TO UNDERSTAND WHAT'S GOING ON IN MY MOUTH, MY PREFERENCE IS:

- To know/discuss all the details ○
- To be shown pictures and videos ○
- To read pamphlets and brochures ○

DO YOU EXPERIENCE THE FOLLOWING?

Gums Bleed While Brushing	○ Yes	○ No
Sensitivity to Hot/Cold	○ Yes	○ No
Frequent Headaches	○ Yes	○ No
Snoring	○ Yes	○ No
Problems with Bad Breath	○ Yes	○ No
Grind/Clench Teeth	○ Yes	○ No
Clicking/Popping When Chewing	○ Yes	○ No

WHEN I THINK ABOUT COMING TO THE DENTIST I FEEL:

- ○ **Comfortable** — I have no anxiety. My past experiences have been pain free.
- ○ **Anxious** — I make myself come but am somewhat uncomfortable.
- ○ **Fearful** — I've stayed away because my past experiences have been traumatic & only come when necessary.
- ○ **Extremely Fearful** — I have avoided the dentist for many years to the detriment of my dental health.

ON A SCALE OF 1-10 (10 BEING THE MOST) HOW HAPPY ARE YOU WITH YOUR SMILE?

☹ 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 ☺

IF I COULD CHANGE SOMETHING ABOUT MY SMILE, IT WOUD BE:

- Whiter ○
- Straighter ○
- Healthier
- Closer spaces ○
- Do you have a gummy smile? ○
- Repair chipped teeth
- Replace missing teeth ○
- Replace crowns that don't match ○
- Replace old fillings

I HAVE A FEAR OR CONCERN ABOUT:

- Not being numb ○
- Being numb ○
- Needles
- Gagging ○
- Loss of control ○
- Being Scolded
- Made to feel ashamed ○
- Losing my teeth ○
- Catching a disease
- Cost of Treatment ○
- Sounds of the dental drill ○
- Waiting

Other: ______________________

NOTICE TO OUR PATIENTS

HANDLING OF YOUR INSURANCE

So that you can be clear on how our office handles dental insurance, we wanted to share the following information with you:

Our diagnosis and treatment recommendations for you are based on what is best for your oral health and not based on what your dental insurance plan will cover or will not cover. Your benefits are related to the type of plan chosen by you and your employer. We are not a part of this contract. Often these benefits are not structured to cover the total cost of dental treatment. We will work with you and your primary insurance to get you maximum benefits and provide financial arrangements to allow you to receive your care.

As a courtesy, Winter Park Smiles will bill your insurance company. Should a patient have secondary insurance, we will file with the insurance company; however, it is never a guarantee that the insurance company will make a payment.

If we do not hear from your insurance company within 60 days of billing, the balance will become your responsibility and it is to be paid in full. The responsibility will become yours to collect the reimbursement from your insurance company. A finance charge of 1.5 % will incur at 90 days.

My healthcare information may be disclosed to Winter Park Smiles for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

CANCELLATION AND BROKEN APPOINTMENT POLICY

When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us as least **48 BUSINESS HOURS** notice. This courtesy makes it possible to give your reserved room to another patient who would like it. A charge of $75 will be charged if you do not show up for your scheduled appointment or for repeated cancellations without 48-hour notice.

Repeated cancellations or missed appointments may result in loss of future appointment privileges as well. We feel that our patient's time is valuable.

Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Our goal is to deliver exceptional care for you and your family in a timely manner, and we appreciate your cooperation by honoring your scheduled appointment times.

Please sign that you have read and understand the above guidelines.

Printed Patient/Guardian Name	Patient/Guardian Signature	Date

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine, for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 30 days treatment is completed, I understand that a 1.5% late charge may be added to my account.

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office. The practice provides this information for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

MESSAGES, MAIL, WIRELESS CALLS AND TEXTING:
I understand you may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, or treatment follow-up. Voice mail messages may contain specific appointment information. I understand that I must tell you if I do not want you to communicate with me like this. I agree and have initialed below for Winter Park Smiles to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

Initial ____________

For the safety and security of Winter Park Smiles, team members and patients, I understand that I may be videoed in either the practice parking lot or in conspicuous/obvious-public places within the dental office.

Initial ____________

I acknowledge and understand that:

- My Protected Health Information may be disclosed and used for treatment planning and decisions, securing payment from third party payers, and/or assessing quality and reviewing the competence of healthcare operations.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I wish to place the following restrictions on disclosure of my health information: ____________________________

I give permission to Winter Park Smiles to discuss my Protected Health Information with the following individuals:

Name	Relationship	Name	Relationship

I acknowledge that a copy of the Winter Park Smiles Notice of Privacy Practices, which contains a more complete description of information uses and disclosures, has been made available to me and I have been given the opportunity to ask any questions that I may have regarding this notice. My consent will terminate on the last day I am seen in this office for treatment.

Patient/Guardian Signature ____________________ Date ____________