Smiles ON MAIN

Patient Registration

Please take a few moments to answer the following questions so we can better assist you with your dental needs.

Patient Information

First Middle Last

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Sex: Male ____ Female ____ Social Security # _____

Email _____ Preferred Name _____

Responsible Party Information (if under 21)

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Birthdate _____ Social Security # _____

Dental Insurance Information

Insured Employer _____ Employer Address & Phone _____

Insured Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group # _____

Insurance Company Address _____

Insurance Co. Phone _____ Subscriber ID# _____

Do you have dual coverage? _____ **If yes, Please complete below**

Insured Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group # _____

Insurance Company Address _____

Insurance Co. Phone _____ Subscriber ID# _____

Emergency Information

In case of emergency, please contact: (someone **OUTSIDE** of your household)

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

(OVER)

Dental History

Former Dentist _____
City/State _____
Date of last visit _____
Date of last exam _____

Please circle all that apply:

Bad Breath
Bleeding Gums
Blisters on lips
Tobacco Usage
Clicking or popping jaw
Dry Mouth
Fingernail Biting
Grinding teeth
Gums swollen/tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth
Burning tongue
Orthodontic Treatment
Pain around ear
Periodontal Treatment
Sensitivity to hot/cold
Sensitivity to sweets
Sensitivity when biting
Sores in mouth
Growths in Mouth
Broken Fillings
How often do you floss? _____

Other Information (Please circle)

How did you decide to join our family of dental patients?

Personal Referral- _____ Phone Book Newspaper Internet Other _____

Consent for Treatment/Insurance Assignment/Financial Responsibility/Office Policies

1) I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of this patient's dental needs. I authorize the doctor, following appropriate diagnosis, to perform all recommended treatment mutually agreed upon by the patient, or representative of the patient, and the doctor.

2) I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of these risks.

3) I hereby authorize Smiles on Main to furnish information to insurance carriers concerning my dental needs and treatment, and I hereby assign to Smiles on Main all payments for services rendered to my dependents or myself. I understand that I am ultimately responsible for full payment of all charges, and Smiles on Main makes no guarantees of my insurance reimbursement. **Payment is expected from you at the time of service for *your part* of the charges. We accept cash, check, Visa, and Mastercard for your convenience.**

4) I understand that I am financially responsible for any and all unpaid amounts incurred in treatment. I understand that accounts that are 90 days past due are subject to a minimum service charge of $5.00 or 1.75% of the outstanding balance per month, whichever is greater.

5) I understand that if my account remains unpaid and is forwarded to a collection agency, I will be responsible for any reasonable collection costs, reasonable attorney fees and a $10.00 fee. I understand that if required, a check of my credit history may be made.

6) I understand that if required/necessary, a check of my credit history may be made.

7) I understand that in the event that my check is returned to Smiles on Main from the bank, I will be charged $30.00. I understand that I will be required to pay the amount of the original check plus the service fee within five business days by a cashier's check, money order, cash or credit card. If I fail to do this my account may be turned over to a collection agency.

8) I understand that a minimum of 24 hours notice is required for cancellation of appointments. A broken appointment fee may be charged to my account and is payable by me if a 24 hour notice is not given.

Your signature below indicates that all information is accurate and correct to the best of your knowledge and that you understand and accept these policies.

_____ _____

SIGNATURE OF PARENT OR RESPONSIBLE PARTY ***DATE***

SMILES ON MAIN HEALTH QUESTIONNAIRE

Please circle each one ↴ **Name:**

1. ARE YOU IN GOOD HEALTH? ..... Y N
   a. LAST PHYSICAL EXAM? _____
2. HAS THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR? ..... Y N
3. NAME OF MEDICAL DOCTOR? _____
   PHARMACY _____
4. ARE YOU NOW UNDER MEDICAL CARE? ..... Y N
   If so, please explain _____
5. HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION? ..... Y N
   If so, please explain _____
6. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
   a. Rheumatic Fever or Rheumatic Heart Disease ..... Y N
   b. Congenital Heart Disease? ..... Y N
   c. Cardiovascular Disease **(PLEASE CIRCLE ALL THAT APPLY)**
      • Endocarditis • Heart Murmur • Heart Attack
      • Coronary Insufficiency • Coronary Occlusion
      • High Blood Pressure • Arteriosclerosis
      • Stroke • Mitral Valve Prolapse
   d. Pacemaker/Defibrillator? ..... Y N
   e. Allergy or Hay Fever or Asthma? ..... Y N
   f. Hives or Skin Rash? ..... Y N
   g. Fainting Spells? ..... Y N
   h. Diabetes? ..... Y N
   i. Hepatitis, Jaundice or Liver Disease? ..... Y N
   j. Arthritis (Rheumatic or Osteo)? ..... Y N
   k. Ulcers (Stomach or Intestinal)? ..... Y N
   l. Kidney Trouble (Nephritis, Etc.)? ..... Y N
   m. Tuberculosis? ..... Y N
   n. Persistent Cough or Cough up Blood? ..... Y N
   o. Venereal Disease (Syphilis, Gonorrhea, Other)? ..... Y N
   p. Epilepsy or Seizure Disorder? ..... Y N
   q. Artificial Joint Prosthesis? ..... Y N
   r. Substance Abuse ..... Y N
      Alcoholism, Drug Addiction Active or Recovering (Circle Whichever)
   s. Immune System Depression? ..... Y N
   t. Organ Transplant? ..... Y N
   u. AIDS or HIV? ..... Y N
   v. Cancer? ..... Y N
   w. Chemotherapy/Radiation? ..... Y N
   x. Thyroid Disease? ..... Y N
   y. SLE (Lupus)? ..... Y N
   z. Steroid Therapy? ..... Y N
7. DO YOU HAVE PAIN IN CHEST UPON EXERTION? ..... Y N
8. SHORT OF BREATH AFTER MILD EXERCISE? ..... Y N
9. DO YOUR ANKLES SWELL? ..... Y N
10. DO YOU GET SHORT OF BREATH WHEN YOU LIE DOWN, OR DO YOU REQUIRE EXTRA PILLOWS TO SLEEP? ..... Y N
11. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS SURGERY, EXTRACTIONS OR ACCIDENTS? ..... Y N
12. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? .... Y N
13. DO YOU HAVE ANY BLOOD OR BLEEDING DISORDERS (ANEMIA, ABNORMAL PLATELET FUNCTION, ETC.)?.. Y N
14. HAVE YOU EVER HAD SURGERY OR X-RAY TREATMENT FOR A TUMOR, GROWTH OR OTHER CONDITION? ..... Y N
15. ARE YOU TAKING ANY OF THE FOLLOWING?
   a. Antibiotics or Antirival Medicine? ..... Y N
   b. Anticoagulants (Blood Thinner)? ..... Y N
   c. Medicine for High Blood Pressure? ..... Y N
   d. Cortisone or Steroids? ..... Y N
   e. Nervous System Medicine (Antidepressants, Antipsychotics, Anti-anxiety)? ..... Y N
   f. Asthma or Respiratory Medicines? ..... Y N
   g. Aspirin or Anti-inflammatory Agent? ..... Y N
   h. Dilantin or other Seizure Medicine? ..... Y N
   i. Antidiabetic Medicine (Insulin, Micronase, Etc.)? . Y N
   j. Digoxin or Drugs for Heart? ..... Y N
   k. Nitroglycerin? ..... Y N
   l. Narcotic Analgesic? ..... Y N
   m. Birth Control "Pill"? ..... Y N
   n. Antabuse? ..... Y N
   o. Recreational Drugs or Substances? ..... Y N
   p. Do you regularly take herbal medicine or dietary supplements? ..... Y N
   q. Any other (Prescription or Over-the-counter)? ..... Y N
16. DO YOU SMOKE, CHEW OR ECIG/VAPE? ..... Y N
17. ARE YOU ALLERGIC TO OR REACTED ADVERSELY TO ANY OF THE FOLLOWING?
   a. Local Anesthetics? ..... Y N
   b. Penicillin or other Antibiotics? **PLEASE LIST** ..... Y N
      _____
   c. Aspirin or other Anti-inflammatory Drugs? ..... Y N
   d. Barbiturates, Sedatives, or Sleeping Pills? ..... Y N
   e. Narcotic Analgesics? ..... Y N
   f. Anti-anxiety or Muscle Relaxant Medicines? ..... Y N
   g. Latex (Rubber Gloves, Etc.)? ..... Y N
   h. Any other? ..... Y N
18. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY OTHER PREVIOUS DENTAL TREATMENT? Y N
   If so, please explain _____
   _____
19. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? ..... Y N
   If so, please explain _____

WOMEN

20. ARE YOU PREGNANT? ..... Y N

The undersigned agrees that the information above is accurate

_____

SIGNATURE ***DATE***

Smiles ON MAIN

NAME: _____ DATE OF BIRTH: _____

MEDICATIONS

Instructions for Patients: Enter all of the prescriptions and over-the-counter medications you are currently taking. **Complete only the first four columns.**

Name of medication	Dosage	Times a day is it taken	What is it taken for?	FOR CLINIC USE ONLY	
				Entry date*	Discontinued**

MEDICAL UPDATES

FOR CLINIC USE ONLY

Medical updates: *Document any significant changes in medical status and/or medications.*

Date	

SMILES ON MAIN

119 South Main Street, Ste. #1, Maquoketa IA 52060

NOTICE OF PRIVACY PRACTICES/PRESCRIPTION CONSENT

Patient's Full Name_____ **Date of Birth**_____

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 give Smiles on Main my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, to view any past prescription histories, to transmit electronic prescriptions, and for health care operations like quality review.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used and disclosed. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

We request that payment be made at the time of service. Please be prepared to pay for your visit today. If you have a copay/co-insurance you will be asked to pay that amount. A photocopy of this assignment is to be considered as valid as an original.

I authorize Smiles on Main to obtain/release or exchange information regarding demographics, appointments, insurance and medical information including test results with the following people:

Name	Phone Number	Relationship to Patient

Messages may be left on my answering machine regarding appointments. Yes_____ No_____

I may be contacted at my workplace. Yes_____ No_____

Signature	Relationship to Patient	Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.
Date: _____Initials:_____Reason:_____