WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.
If you have any questions, or if we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____ If child, parent/guardian name) _____
Last name First name Initial

Birth date _____ Sex _____ Age _____ Social Security Number_____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail _____ Driver's License Number _____

How did you hear about our practice? _____
Employer _____ Occupation _____ How long there? _____ May we call? _____
Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Social Security Number _____
Spouse's Employer _____ Occupation _____ How long there? _____ May we call? _____
Spouse's Employer Address _____ City _____ State _____ Zip _____

If patient is a student: Name of school / college: _____ City & State _____ Full time or part time? _____

Primary Insurance:

Name of Insured_____
Birth date _____ Relationship to Patient _____
Address _____
Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID# _____
Group, Contract or Local or union # _____
Address (if different from patient) _____

Additional Insurance:

Name of Insured _____
Birth date _____ Relationship to Patient _____
Dental Insurance Co._____ Phone _____
Social Security # _____ Subscriber ID# _____
Group, Contract or Local or union # _____

Copayments:

If you would like us to keep your payment information on file, please provide credit card information or voided check:
CIRCLE ONE: Visa MasterCard Discover Amex
Account# _____ Expiration date _____ Name on the card
_____

☐ Credit Card ☐ Debit Card ☐ ATM ☐ Voided check attached

In Case of Emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you: _____ Phone #'s (home, work, cell) _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts. I have received a copy of this office's Notice of Privacy Practices.

Signature_____

Date_____

Dental History

Patient's Name _____ Age _____ Date _____
Reason for seeking care today: _____ Exam _____ Cleaning _____ Specific Problem _____
(please describe)

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums Bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe – Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Why did you leave your previous dentist? _____
Did your parents have difficulties with their teeth or dental treatments? _____

Medical History

Physician's Name: _____
City _____ Phone _____
Have you been hospitalized for any reason? Please Describe:
_____
_____
_____
Are you taking any medications or drugs (including nutritional supplements)? Please list :(continue on back of form if needed)
_____
_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other?
_____
_____
Do you smoke? How much / day? _____
Pregnant? ____Due date? _____ Are you nursing? _____
Are you seeing a physician now or planning to see one for any reason? Please explain:
_____
_____

Please check all that apply:

- ☐ Previous injury to head or neck
- ☐ Shortness of breath
- ☐ Snoring, sleep apnea
- ☐ Easily winded
- ☐ Bleed or bruise easily
- ☐ Stroke
- ☐ Cancer
- ☐ Mitral valve prolapse
- ☐ Parkinson's
- ☐ Respiratory problem
- ☐ High or low blood pressure
- ☐ Two or more social drinks / day
- ☐ Hives, rash, Herpes
- ☐ Anemia
- ☐ Sickle cell
- ☐ Diabetes
- ☐ Heart problem
- ☐ Heart attack
- ☐ Angina, chest pain
- ☐ No energy
- ☐ Fainting or dizzy
- ☐ Epilepsy or seizures
- ☐ Radiation, Chemotherapy
- ☐ Chewing tobacco
- ☐ Alzheimer's
- ☐ Bloody, persistent cough
- ☐ Pacemaker
- ☐ Anxiety or nervous disorder
- ☐ Dry eyes
- ☐ Contact lenses
- ☐ Digestive problems, ulcer
- ☐ HIV or AIDS
- ☐ Kidney problem
- ☐ Liver problem, jaundice
- ☐ Heart murmur
- ☐ Scarlet, Rheumatic fever
- ☐ Unexplained weight loss
- ☐ Irregular heartbeat
- ☐ Drug or alcohol addiction
- ☐ Thyroid disease
- ☐ Glaucoma
- ☐ Cirrhosis, Hepatitis
- ☐ Back problem
- ☐ Asthma, Emphysema
- ☐ Artificial joint
- ☐ Insomnia

Any other illnesses not checked above _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No
Please rate the following indicators of your daily stress level: 1-10: (1 = low, 10 = high)
____ Overworked, too busy, pressured_____ Feel frustrated _____ Get upset, or "snap" easily _____ Depression anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or both. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian)_____ Date _____

Dentist Signature_____ Date _____

CLASSIC SMILES

FAMILY, IMPLANT & COSMETIC DENTISTRY

We love to care for your smile...

Website and Social Media Release Form

I, the undersigned, do hereby grant permission to Classic Smiles to post my photo and/or story, or other item, hereinafter referred to as "Materials," the Classic Smiles website, Twitter account, and/or Facebook account.

I hereby release you, your representative, employees, managers, members, officer, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said :Materials," including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

I acknowledge and agree that no sums whatsoever will be due to me as a result of the use of the "Materials" or any rights therein.

Patient/Guardian Signature: _____

Print Name: _____

Date: _____

I acknowledge that my child is under 18 years old and lacks the legal capacity to enter into binding agreements. Accordingly, I have read this release and consent to my child's inclusion in the Materials will not contest the rights granted in the release, and shall assist and support you in any and all legal proceeding for affirmation of this agreement, should you choose to have a court of law affirm the agreement.

Child's Name: _____

Parent/Guardian Signature: _____

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Patient Signature Page

I. Notice of Privacy Practices

By signing below, I acknowledge that I have read Classic Smiles Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: _____ Date: _____

II. Payment, Insurance, and Financial Arrangement Policies

By signing below, I agree to the terms of the Classic Smiles Patient Acknowledgements, Agreements, and Authorizations document.

Signature: _____ Date: _____

III. Appointment Agreement

In order for us to respect the time of all of our patients, we ask that you help us in regards to the appointments that have been especially reserved for you! Please be on time for your appointments. Your appointment time is reserved specifically for you. Arrivals of 10 minutes or more past your reserved time will be re-evaluated for what can be done that day.

Signature: _____ Date: _____

IV. Release of Information to Insurers and Assignment of Benefits

I consent to Classic Smiles' use and disclosure of my Protected Health Information to carry out payment activities in connection with insurance claims. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Classic Smiles.

Signature: _____ Date: _____
(If patient is a minor or disabled the Parent, Guardian, or Attorney-in-Fact must sign and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled)

First: _____ Middle: _____ Last: _____ Jr/Sr: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Patient SSN: _____-- _____--_____ Patient Date of Birth: _____/_____/_____

Sex: (circle) M / F