PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS# Not needed Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

If you do not have dental benefits (dental insurance) please type in "none" in areas where information is required

Comments:

Signature:

Date:

Designing Smiles Medical History

Last Name: First Name: Birthdate:

Emergency Contact: _____ Phone: _____ Relationship:

Name of Medical Doctor: _____ Location/Phone: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part your entire body, Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.Thank you for answering the following questions.

List all medications including regular intake of grapefruit, vitamins, herbal supplements, fish oil, etc.

More than 5 medications, please email a picture of your medication list/labels to info@smilesmn.com

_____

_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Erythromycin	☐	☐	Penicillin	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Latex	☐	☐	Seasonal	☐	☐	Other: _____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Alcohol/Chemical Dependency	☐	☐	Diabetes	☐	☐	Neurological Disorders
☐	☐	Anxiety / Nervousness	☐	☐	Epilepsy / Seizures	☐	☐	Osteoporosis/Osteopenia
☐	☐	Asthma/Lung Disease	☐	☐	Glaucoma	☐	☐	Pregnancy/Nursing
☐	☐	Arthritis/Rheumatoid Arthritis	☐	☐	Heartburn / GERD / Reflux	☐	☐	Psychiatric Treatment
☐	☐	Artificial Joints/Valves	☐	☐	Heart Problems	☐	☐	Recreational Drug Use
☐	☐	Blood Transfusion	☐	☐	Mitral Valve Prolapse	☐	☐	Rheumatic Fever
☐	☐	Bulimia/Eating Disorder	☐	☐	Hepatitis	☐	☐	Sinus Trouble
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Sleep Apnea
☐	☐	Cold Sores	☐	☐	HIV / AIDS	☐	☐	Stroke
☐	☐	Chemo/Radiation Therapy	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Depression	☐	☐	Liver Disease	☐	☐	Tuberculosis

Please list any other Medical Conditions/Recent Surgeries/Hospitalizations that may not be listed above:

_____

Do you consume soda/hard candies/frequent snacks? _____

Tobacco use? ☐ Y ☐ N If Yes, what kind and how much?

How would you rate your stress level? ☐ High ☐ Moderate ☐ Low

How would you rate the quality of your sleep? ☐ Very Restful ☐ Adequate ☐ Poor/Interrupted

Comments:

Signature:

Date:

designing smiles

Patient Financial/ Care Agreement

Our primary goal is to provide you with exceptional oral health care. In our office, we strive to maximize your insurance benefits and make payment options straightforward so we can focus on providing you with quality care. Our fees are based on the quality of dental materials we use and the time, effort and skill required for your needed treatment. We will be sensitive to your financial circumstances; ultimately, however, you are responsible for payment regardless of any insurance benefits.

Fist Name: Last Name: Birthdate:

Please Initial On Each Line

_____ If you have dental benefits, we are happy to submit the claims for you. However, coverage is not guaranteed. Your dental benefits are an agreement between you and your benefit company and you will be responsible for all treatment fees.

_____ Payment is expected on the day of treatment. If you have dental benefits, we will collect your estimated portion of the procedure fees. We accept the following forms of payment: cash, check, credit/debit cards (Visa, MasterCard, American Express and Discover).

_____ In addition we offer CareCredit, a patient payment program offering a full range of no interest and extended payment plans for treatment.

_____ Rescheduling Appointments We realize that your time is valuable. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments prevents other patients from opportunities. If you find that you must change your appointment, we require a minimum of a 48 hour notice so that we may make every effort to accommodate other patients. If proper notice is not received, a reservation fee may be required to schedule any future appointments.

_____ If Applicable- My son or daughter is a dependent and is 18 years or older or is under 18 years of age. I understand and accept full responsibility for all charges or payments due.

Name of Responsible Party:

We thank you for trusting us with your dental health care! We are proud to consider you part of our smile family!

I have read and agree to the above Patient Care Agreement.

Signature of Patient or Responsible Party

Date:

Authorization Consent Form/HIPAA Privacy Notices

Last Name: _____ First Name: Birthdate:

Medical Records Release:

I agree to the release of any records and photos necessary for treatment, referral, billing, or insurance purposes. These records may need to be shared with other clinical providers for treatment purposes as well.

Yes No

☐ ☐ Initials

Photo Release:

I hereby release photos of myself (or my child) taken by Designing Smiles for promotional purposes and materials including the Designing Smiles website.

Yes No

☐ ☐ Initials

Treatment Authorization for a child/minor:

If a parent or guardian is unable to be present for treatment to be performed, I authorize staff at Designing Smiles to perform the necessary procedures as agreed upon per veral or written consent including, but not limited to, Radiographs (Xrays), Fluoride treatment,and sealants.

Yes No

☐ ☐ Initials

Clinical Information Release Authorization:

I authorize Designing Smiles to disclose/discuss my clinical records and treatment with my parent/guardians. I understand that I have the right to revoke this authorization, in writing, at any time.

Yes No

☐ ☐ Initials

I, _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

By signing this form, you are assuming responsibility for all charges regardless of insurance coverage.

Patient/Parent/Guardian Signature: _____

Date: