# Smiley Family Dentistry

2024 3rd Avenue NW, Suite A  Waverly, Iowa 50677

We thank you for choosing our office. Please know that it is our goal to make your dental experience a positive one. Please fill out the information below in detail to help us get to know you better. Thank you again for allowing us to serve your dental needs.

## Patient Information

**Patient Name:** _____
Last First Middle Initial Preferred Nickname

**Mailing Address:** _____
Address City State Zip

**Email Address:** _____

**Gender:** Male Female **Birth Date:** ____/____/____ **Social Security Number:** _____

**Marital Status:** Single Married Widow Separated Divorced

Home Phone #: _____ Cell Phone #: _____

**Best way to confirm appointments:** _____ Text _____ Email _____ Phone (best number to use) home or cell

**Parents/Guardians if under 18 (please print names):** _____

Employer: _____ Work Phone #: _____

If student, name of School: _____ City: _____ Grade: _____

Other Contact (relative or friend **NOT** living at your address): _____ Phone: _____

**Whom may we thank for referring you to our office:** _____

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## Dental Insurance

**Primary Carrier**

Subscriber Name: _____ Relationship to Patient: _____

Insurance # or SS #: _____ Birthdate: ____/____/_____

Employer: _____

**Secondary Carrier**

Subscriber Name: _____ Relationship to Patient: _____

Insurance # or SS #: _____ Birthdate: ____/____/_____

Employer: _____

**Insurance Authorization Statement**

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. Our Dental office is only able to estimate the dental insurance payment. I understand that I am responsible for all costs regardless of my insurance coverage. The information on this page is correct to the best of my knowledge.

**Signature:** _____ **Date:** _____

## Dental Health and Appearance

What is your primary dental concern?_____

Approximate date of last dental visit: _____ Were X-rays taken? **Yes** **No**

Name of previous dentist: _____ City/State:_____

Why did you leave your previous dentist?_____

What did you like **most** about your previous dentist? _____

What did you like **least** about your previous dentist? _____

Do you feel nervous about having dental treatment? _____

Please rate your smile from 1 to 10. (10 being highest) _____

Is there anything you would like to change about your smile? _____

Would you like whiter teeth? _____

**Please answer the following:**

| | | | | | |
|---|---|---|---|---|---|
| **Yes** | **No** | Do you feel pain to any of your teeth? | **Yes** | **No** | Do you have frequent headaches? |
| **Yes** | **No** | Are your teeth sensitive to sweet, hot or cold? | **Yes** | **No** | Do you get sinus pain or pressure? |
| **Yes** | **No** | Are you aware of any broken teeth? | **Yes** | **No** | Do you have popping or clicking in jaw joints? |
| **Yes** | **No** | Do you have any sores or lumps in your mouth? | **Yes** | **No** | Do you have jaw pain? (joint, ear, side of face) |
| **Yes** | **No** | Do your gums bleed while brushing/flossing? | **Yes** | **No** | Do you clench or grind your teeth? |
| **Yes** | **No** | Have you been treated for "gum disease"? | **Yes** | **No** | Difficulty in opening or closing? |
| **Yes** | **No** | Do your gums feel swollen or tender? | **Yes** | **No** | Have you had any head, neck or jaw injuries? |
| **Yes** | **No** | Have you had any difficult extractions before? | **Yes** | **No** | Difficulty in chewing? |
| **Yes** | **No** | Do you have any loose teeth? | **Yes** | **No** | Do you wear dentures or partials? |
| **Yes** | **No** | Do you use tobacco? | **Yes** | **No** | Have you had braces? |
| **Yes** | **No** | Do you have bad breath, or a bad taste in your mouth? | | | |
| **Yes** | **No** | Have either of your parents lost their teeth to gum disease or been treated for gum disease? | | | |
| **Yes** | **No** | Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | | | |

How do you feel about getting and maintaining a healthy mouth?_____

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## Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and /or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

For purpose of teaching, research and scientific publication, the dentist may us photographs, radiographs, or other diagnostic materials. The identity of the patients will remain anonymous. The patient may view this material for consent and refuse this request.

**Payment for all treatment and services rendered are my responsibility.**

**Sign Here:** _____ **Date:** _____

**Patient/Parent/Guardian Signature**

## Agreement to Pay

I agree to **FINANCIAL RESPONSIBILITY** for my/my family's treatment. In the event a quotation of fees is not given to me before the services being performed, I shall ask for such a quotation or waive my right to later claim the fees exceeded the value of services rendered.

In the event that payment for dental services is not made within ninety (90) days of the receipt of statement, then a service fee of 1.5% per month (18% annually) will be added to the past due balance. If collection services or legal services are required to obtain payment of the amount billed, I further agree to pay for all legal fees and costs reasonable incurred in connection with my therewith. I may request a copy of this form.

**Responsible Party Signature:** _____ **Date:** _____

**IF PATIENT IS UNDER 18**

Please be aware of our office policy regarding financial responsibility of children of more than one family: The parent bringing in the child and scheduling appointments will be responsible for charges incurred. The parents will be responsible for communicating to each other regarding costs and appointments.

**Responsible Party Signature:** _____ **Date:** _____

Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip _____

Telephone (_____)_____

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## Consent for Use and Disclosure of Health Information

**TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**PURPOSE OF CONSENT-** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**NOTICE OF PRIVACY PRACTICES:** You have the right to read our Notice of Privacy Policy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**RIGHT TO REVOKE:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Permission to release information to person listed below not living in same household:

**Name & Address:** _____

I have had full opportunity to read and consider the contents of the above Consent form, your Notice of Privacy Practices, and your agreement to pay policy. I understand by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment and health care operations.

**SIGNATURE:** _____ **DATE:** _____

# Smiley Family Dentistry

Medical History and Information

Your answers are for our records and will be confidential.

Patient Name _____ BIrthdate _____

Name of Physician _____ Primary Pharmacy _____

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain if yes:_____

Do you currently or have you ever had the following medical conditions?

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Abnormal/excessive bleeding | Yes | No | Heart Attack |
| Yes | No | ADHD/ADD | Yes | No | Heart Murmur |
| Yes | No | Alzheimer's/Dementia | Yes | No | Heart surgery |
| Yes | No | Anemia | Yes | No | Hemophilia |
| Yes | No | Angina | Yes | No | Hepatitis |
| Yes | No | Anxiety | Yes | No | Jaundice or Liver disease |
| Yes | No | Arthritis | Yes | No | High Blood Pressure |
| Yes | No | Artificial Heart Valve | Yes | No | High Cholesterol |
| Yes | No | A.R.V.D. | Yes | No | Infectious Diseases |
| Yes | No | Autism or Asperger's | Yes | No | Joint Replacement |
| Yes | No | Asthma | Yes | No | Kidney problems |
| Yes | No | Autoimmune disease | Yes | No | Leukemia |
| Yes | No | Behavioral/Mental Condition | Yes | No | Lymes Disease |
| Yes | No | Blood Disease | Yes | No | Mitral Valve Prolapse |
| Yes | No | Blood Thinners | Yes | No | MRSA |
| Yes | No | Blood Transfusion | Yes | No | MS |
| Yes | No | Breathing problems/Respiratory disease | Yes | No | Osteoporosis/Paget's Disease |
| Yes | No | Cancer (type _____) | Yes | No | Pacemaker |
| Yes | No | Cardiovascular Disease | Yes | No | Parkinson's Disease |
| Yes | No | Congestive Heart Failure | Yes | No | Pregnant |
| Yes | No | Damaged Heart Valves | Yes | No | Pre-Medication |
| Yes | No | Decreased Immunity-drug, disease,transplant | Yes | No | Rheumatic fever |
| Yes | No | Depression | Yes | No | Rheumatic Heart Disease |
| Yes | No | Diabetes | Yes | No | Rheumatoid Arthritis |
| Yes | No | Down Syndrome | Yes | No | Severe headaches/Migraines |
| Yes | No | Drugs for Osteoporosis | Yes | No | Sinus trouble |
| Yes | No | Eating Disorder | Yes | No | Sleep Apnea |
| Yes | No | Emphysema | Yes | No | Spleen removal |
| Yes | No | Endocarditis | Yes | No | Stroke |
| Yes | No | Epilepsy | Yes | No | Substance/Alcohol Abuse |
| Yes | No | Fainting spells or seizures | Yes | No | Thyroid problems |
| Yes | No | Fibromyalgia | Yes | No | TMJ Disorder |
| Yes | No | G.E. Reflux/persistent heartburn | Yes | No | Tobacco use |
| Yes | No | Glaucoma | Yes | No | Tuberculosis |
| Yes | No | Gout | Yes | No | Ulcers |
| Yes | No | Hearing difficulties | Yes | No | Vision impaired |
| Yes | No | Other Medical conditions? Explain: _____ | | | |

## ALLERGIES

Are you allergic to or do you suffer ill effects from any of the following?

☐ Penicillin ☐ Amoxicillin ☐ Latex/Rubber ☐ Metals
☐ Codeine or narcotics ☐ Aspirin ☐ Ibuprofen ☐ Sulfa
☐ Antibiotics _____ ☐ Other _____

## MEDICATIONS: Please list any medications, including OTC, "natural", or supplement

_____

_____

_____

Signature _____ Date _____

SMILEY
Family Dentistry
*Restoring Health. Celebrating Smiles.*

2024 3rd Ave. NW • Suite A
Waverly, IA 50677
***(319) 352-2270***

## Cancellation & No-Show Policy

Our goal at Smiley Family Dentistry is to provide quality dental care in a timely manner. We appreciate you and understand time is valuable which is why we make every effort to keep you from waiting. To respect the needs of all patients, we require a 24 hour cancellation notice. Appointments are in high demand and your early cancellation will give another person the opportunity to access timely dental care.

We allow for two late cancellations as a courtesy to our patients. A late cancellation occurs when it is less than 24 hours notice. Appointments will not be rescheduled after two late cancellations and the patient may be dismissed from our office. Habitual cancelled/rescheduled appointments may also result in being dismissed. A "no-show" appointment occurs when a patient misses without notifying the office. The first no-show will be a warning and the appointment may be rescheduled. If a second no-show occurs the patient may be dismissed from our office.

By signing below I certify that I have read and understand the terms and conditions of Smiley Family Dentistry's Cancellation and No-Show Policy.

_____ _____
Patient/Parent/Guardian Signature Date

_____
Print Patient Name