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: _____

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?_____

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 (_____)_____

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 _____