GLOWING SMILE DENTAL STUDIO

Welcome! So that we may provide you with the best possible care, please complete this patient information form.

1 PATIENT INFORMATION: Please complete patient information below

Last Name:	First Name:	M.I.
Date of Birth:	Sex : Male Female	Social Security #:
Driver's license #:	Email address:	
Street Address:	Suite/ Appt.:	City/ State / zip
Patient Home/ cell #:	Emergency contact and phone #:	
Relationship to emergency contact:	Who can we thank for referring you?	
Who is responsible for my account balance (after insurance)?		

2 INSURANCE BENEFITS: Please complete patient insurance benefits below

Primary Insurance Company	Policy Holder:		Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's ID#:	Group #:	Insurance Company Phone:
Policy Holder's Address:	City/ State/ Zip:		Employer:
Secondary Insurance Company	Policy Holder:		Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's ID#:	Group #:	Insurance Company Phone:
Policy Holder's Address:	City/ State/ Zip:		Employer:

For patients WITH insurance: We will accept assignment of benefits from the insurance companies with the understanding that the patient is responsible for their estimated portion at the time of services, and is further understood that the patient's portion is **only an estimate expected from your insurance and we cannot guarantee your insurance benefits or payments.** If your insurance does not pay in sixty (60) days, you will be responsible for the balance on your account.

INITIALS: _____

3

MEDICAL HISTORY: Please complete medical / dental history below:

Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No	Nervous/Anxious	Yes	No
A.F.I.B.	Yes	No	Fainting/ Dizzy Spells	Yes	No	Neurological Disorders	Yes	No
Arthritis/Rheumatism	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No
Artificial Valve	Yes	No	Hay Fever	Yes	No	Psychiatric Care	Yes	No
Artificial Joints	Yes	No	Heart (Surgery, Disease, Attack)	Yes	No	Radiation Therapy	Yes	No
Asthma	Yes	No	Heart Pacemaker	Yes	No	Rheumatic Fever	Yes	No
A.I.D.S.	Yes	No	Heart Murmur	Yes	No	Sickle Cell Disease	Yes	No
Blood Transfusion	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Bruise Easily	Yes	No	Hepatitis A B C	Yes	No	Stroke	Yes	No
Chemotherapy	Yes	No	High Blood Pressure	Yes	No	Swollen Ankles	Yes	No
Chest Pain	Yes	No	High Cholesterol	Yes	No	Thyroid Problems	Yes	No
Congenital Heart Disease	Yes	No	H.I.V. Positive	Yes	No	Tuberculosis	Yes	No
Cortisone Medicine	Yes	No	Kidney Trouble	Yes	No	Tumors	Yes	No
Cold Sores	Yes	No	Latex Sensitivity	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Mitral Valve Prolapse	Yes	No	Yellow Jaundice	Yes	No

1. Do you have, or have you had any disease, condition, or problem not listed? YES NO
   If so, list here _____

2. **Women:** Are you: **Pregnant?** YES, ___ Months/ NO **Nursing?** YES NO
   On contraceptives? YES NO

3. Have you been under the care of a medical doctor during the past two years? YES NO
   If yes, for what?_____
   Physician's name _____ Phone_____
   Address _____

4. Have you been a patient in the hospital during the past five years? YES NO
   If so, please indicate why, _____

Extra comments:

NITIALS: _____

Please List Medications that you are taking:	
1.	5.
2.	**6.**
3.	**7.**
4.	**8.**

1. Are you aware of any allergic /adverse reactions to any medications or substance? YES/NO
If so, please list them here,_____
_____

2. Are you taking any medication for Osteoporosis?
Fosamax Boniva Prolia Other:_____

3. Have you taken any Bisphosphonates, medicines for osteoporosis/bone disease in the past? Yes No

Signature _____

What is the reason for your visit today?_____

Date of Last Dental Visit	Date of Last Cleaning	Last Full Mouth X-Rays

Please choose yes OR no to indicate if you have any of the following.					
Bad Breath	Yes	No	Sensitivity on hot/ cold	Yes	No
Bleeding Gums	Yes	No	Sensitivity to sweets	Yes	No
Burning Tongue	Yes	No	Pain on Biting	Yes	No
Smoking	Yes	No	Snoring	Yes	No
Clicking/ Popping of the Jaw	Yes	No	Mouth Breathing	Yes	No
Jaw Pain	Yes	No	Grinding/ Clenching Teeth	Yes	No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my ability and knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature _____ **Date** _____
Printed Name:_____

4 FOR MINORS

I herby acknowledge that I am _____
the legal guardian of _____
and that I have the legal custody as a **(parent/ relative/ legal authority)** of the above mentioned minor. I underatand that all the above information is correct and should any changes happen Glowing Smile Dental Studio will be updated of any changes.
In case if you do not have the parental right: Please provide documentation indicating appointment of Legal Authority/Guardianship or Personal Representative.

Parent/Guardian Signature _____ **Date** _____
Printed Name:_____

In the event that there will be another adult that you authorize to accompany your minor to their dental appointmnets, sign dental treatments plans, and share medical/ dental information with, please ask for a PARENTAL RIGHT POLICY FORM to give Glowing Smile Dental Studio the permission to do so.

- As a standard office policy,please note parents/ guardian are not allowed to accompany the minor to the clinical area at any times.

Parent/Guardian Signature _____ **Date** _____
PrintedName:_____

5 CONSENT FOR TREATMENT

1. I hereby authorize doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis for my dental needs.
2. Upon such diagnosis, I authorize the treating doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary.
4. I understand the treatment estimate presented to me is **ONLY an estimate.** Occasionally, the need may arise to modify the treatment procedures and its fee.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made.

Patient/ Guardian signature: _____ **Date**:_____
Printed Name:_____

6 HIPAA PRIVACY

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the"Policy") of Glowing Smile Dental Studio (the "Provider"), and have been offered a copy of such policy to keep for my records.

I hereby acknowledge that I have read the Policy and understand its terms and conditions

Patient's/ Guardian's signature: _____Date:_____

7 FINANCIAL POLICY

We are committed to providing dental care and the finest service possible for all our patients. Good communication concerning dental problems, treatment procedures, and fees is one of our most important goals. In order to minimize expense, we request payment for services at the time they are rendered. Payment for services may be made in any of the following ways:

Option #1: Cash or check at the time of services is rendered.
Option #2: Debit card, Master Card, Visa, Discover is accepted.
Option #3: We can help you financing for your dental treatment through Care Credit or other creditors.
Please read our financial policy for more information for courtesy discount and patients with insurance.

APPOINTMENT POLICY
The nature of our practice is to provide extremely high quality care that requires at times longer appointment for each of our patient visits. It is our policy that 48 hours' notice must be given if you are forced to cancel an appointment. After **3 broken or cancelled appointments within less than 48 hours**, we will place your file in an "inactive status" and special arrangements must be made to reactivate it.
We reserve the right to charge at least $50.00 broken dentist/ hygienist appointment fee without 48 hours' notice. Please refer to the office financial policy for more details.

I have received and read the Full Financial policy provided to me. (If not please request the full financial policy)

Patient's/ Guardian's signature: _____Date:_____