PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

Signature of patient (or parent) _____ Date _____

Division Smiles

Financial Agreement and Cancellation Policy

As a service to our patients, we would like to outline our policy toward the payment of service:

1. I understand that all responsibility for dental services provided in this dental office for myself or my dependents is entirely mine, due and payable at time of services are rendered unless other arrangements have been made.

2. Payments may be made by cash, check, credit card, or care credit. We reserve the right to charge a $25.00 fee for all checks returned for non-sufficient funds.

3. I hereby authorize and direct my insurance company to pay any benefits due to me directly to this dental office. I understand that a billing fee will be assessed to my account for any outstanding balances past due beyond 30 days. I also understand that if the insurance information is not correct and/or I do not have my insurance information available at time of service I will also be held financially responsible for any and all charges incurred.

4. I grant my permission to Division Smiles to telephone me at my home or at my workplace to discuss matters related to my account.

5. Division Smiles may send cell phone texts or email reminders.
   ☐ I do not want email or text reminders

Scheduled appointments are reserved specifically for you. If you need to change an appointment please contact the office with at least 48 hour notice. **There will be $30 fee for missed or short notice canceled appointments.**

We realize that time is very important to you, and we make every effort to stay prompt. We ask you have the same consideration by being on time for your appointments.

_____ _____

Signature of Patient, Parent or Guardian Date

_____

Print Patient Name

DIVISION SMILES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)