Welcome to

Smile Shapers

Family and Cosmetic Dentistry

Adult Medical History

PATIENT INFORMATION

Name: *(Last, First, M.I.)*		DOB:	☐ Male ☐ Female
Home Address:		Home Phone: ( )	
City/State/Zip		How long at this address?	
Driver's License No.:	Soc. Sec. No.:	Cell Phone: ( )	
Employer:	Occupation:	Work Phone: ( )	
Who may we thank for referring you to our office?			
Date of last dental visit:	Email:		
Primary reason for this visit?			
Spouse/Responsible Party: *(Last, First, M.I.)*		DOB:	☐ Male ☐ Female
Home Address: *(If different from patient)*		Home Phone: ( )	
City/State/Zip		How long at this address?	
Driver's License No.:	Soc. Sec. No.:	Cell Phone: ( )	
Employer:	Occupation:	Work Phone: ( )	

EMERGENCY CONTACT INFORMATION

Primary Contact:	Secondary Contact:
Relationship:	Relationship:
Phone: ( ) Cell: ( )	Phone: ( ) Cell: ( )

DENTAL INSURANCE INFORMATION

PRIMARY	
	Insured's Name:
	Date of Birth: SSN:
	Employer:
	Relationship to subscriber:
	Insurance Company:

SECONDARY	
	Insured's Name:
	Date of Birth: SSN:
	Employer:
	Relationship to subscriber:
	Insurance Company:

MEDICAL INFORMATION

Physician Name:	Phone: ( )	Fax: ( )
Physician Address:		Date of Last Exam:

DOCTOR UPDATES

DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X

Continued on reverse. Please complete both sides.

MEDICAL HISTORY

Certain illnesses and drugs may have a direct effect on the oral cavity and, consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary that **Smile Shapers** has the following information.

Please check [✓] if you have or have had problems with any of the following:

☐ AIDS/HIV Positive	☐ Claustrophobia	☐ Hemophilia	☐ Rheumatic Fever
☐ Allergies	☐ Congenital Heart Disease	☐ Hepatitis Type _____	☐ Scarlet Fever
☐ Anemia	☐ Contact Lenses	☐ Herpes	☐ Shortness of Breath
☐ Angina	☐ COPD	☐ High Blood Pressure	☐ Seizures
☐ Anxiety	☐ Cortisone Treatments	☐ Jaundice	☐ Sinus Trouble
☐ Arthritis, Rheumatism	☐ Cough, persistent or bloody	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Heart Valves		☐ Kidney Disease	☐ Special Diet
☐ Artificial Joints	☐ Diabetes	☐ Leukemia	☐ Stroke
☐ Asthma or Hay Fever	☐ Emphysema	☐ Liver Disease	☐ Swollen Feet or Ankles
☐ Back Problems	☐ Endocarditis	☐ Low Blood Pressure	☐ Swollen Neck Glands
☐ Bleeding abnormally, with extractions or surgery	☐ Epilepsy	☐ Measles or Mumps	☐ Thyroid Problems
	☐ Fainting or dizziness	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Blood Disease	☐ Fibromyalgia	☐ Nasal Obstruction	☐ Tuberculosis
☐ Blood Transfusion	☐ Glaucoma	☐ Neurological Problems	☐ Tumor or growth on head or neck
☐ Cancer Therapy	☐ Headaches	☐ Pacemaker	
☐ Chemical Dependency	☐ Heart Attack	☐ Psychiatric Care	☐ Ulcer
☐ Chemotherapy	☐ Heart Murmur	☐ Radiation Treatment	☐ Venereal Disease
☐ Circulatory Problems	☐ Heart Disease	☐ Respiratory Disease	☐ Weight Loss, unexplained

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs.

Check [✓] the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

☐ Anesthetics, Locally Injected	☐ Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)
☐ Anesthetics, General	
☐ Antacids	☐ Heart Medications such as Digoxin, Nitroglycerin or Digitalis
☐ Anti-anxiety Medications	
☐ Anti-depressants	☐ Ibuprofen (Motrin)
☐ Antihistamines	☐ Insulin or Diabetes Medications
☐ Daily Aspirin Regimen	☐ Sedatives or Tranquilizers
☐ Birth Control Pills	☐ Sleeping Pills (Barbiturates)
☐ Blood Pressure Medications	☐ Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine
☐ Codeine, Demerol or Other Analgesics	
☐ Cortisone or Other Steroids	☐ Tylenol (Acetaminophen)
☐ Coumadin, Heparin, Warfarin or other blood thinners	☐ Adverse reaction to any other medication or drug? Please specify:
☐ Dilantin	
☐ Diuretics (water pills)	

Check [✓] current uses/conditions:

	YES	NO
1. Tobacco (Packs per day:_____)	☐	☐
2. Alcohol, Beer, Wine (Drinks per day:_____)	☐	☐
3. Street Drugs (Times per day:_____)	☐	☐
4. Caffeine (Cups per day:_____)	☐	☐
5. High Stress (Reason:_____)	☐	☐
6. Serious illnesses or surgeries *Please describe:*_____	☐	☐
7. Women: Pregnant?	☐	☐
8. Women: Nursing?	☐	☐
9. Are there any other health problems not listed *Please describe:*_____	☐	☐

Please list all medications you are currently taking:

_____ _____ _____

_____ _____ _____

PATIENT SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

I hereby certify that the information provided on this form is true and correct in its entirety. By signing this form, I acknowledge my responsibility for any professional fees incurred for dental services provided.

I authorize **Smile Shapers** to release my dental records to the insurance carrier(s) named on the reverse side for insurance purposes.

Signed X **Date**

Smile Shapers
Family & Cosmetic Dentistry

General Dentistry Informed Consent Form

Treatment Plan… I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. For example, root canal therapy following routine restorative procedures.

Drug and Medications… I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

Extractions… Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedure, periodontal therapy, etc.) and I understand removing teeth does not always remove the infection, if present, and may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Crowns, Bridges, Veneers… I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Endodontic Therapy… I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand the endodontic files and reamers are very fine instruments and stresses and defects in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following the root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to restore it.

Periodontal Disease… I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

Fillings… I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that significant sensitivity is a common after effect of newly placed fillings.

Partials and Dentures… I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline due will be needed at a later date. This IS NOT included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

_____

Patient Signature, Parent/Guardian Date

Smile Shapers
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Information Regarding Bisphosphonates

Bisphosphonate are a class of drugs that are used to treat osteoporosis in women. Stronger forms of bisphosphonates are sometimes used in the treatment of certain cancers, as well as for a disorder called Paget's disease.

A connection has been made between bisphosphonate type drugs and a serious bone disease called Osteonecrosis of the Jaw. The United States Food and Drug Association, along with the manufacturer of one of these drugs (Fosamax) issued a warning to health care professionals on this issue on September 24th, 2004.

It is very important for you to let us know if you are now, or have ever in the past, taken ANY type of bisphosphonate class drug. If we treat you without knowing if you are now, or have ever taken in the past, any of these drugs, your health could be seriously affected. These drugs continue to affect the body for years after they are no longer being taken, so we must know if you have ever taken any of them. Brand names of these drugs include (but are not limited to) the following:

Fosamax
Zometa
Aredia
Actonel
Boniva
Bonefos
Skelid
Didronel

Are you now, or have you in the past, taken a bisphosphonate drug, including any of the brands listed above?

YES_____ NO_____ DATE_____

_____
Patient Signature **Date**

Information on the Election of Treatment

Your dentist will design a treatment plan in which he/she will recommend that you undergo specific dental procedures. You will be presented with the optimum treatment for your particular dental needs. If, in the dentist's judgment, other acceptable treatment options exist, these will be discussed with you as well. There are likely to be increased risks and potential complications should you elect to have an alternative form of treatment that differs from the optimum treatment plan presented to you. Please discuss these issues in more detail with your dentist. Be sure to understand the potential risks and complications before consenting to treatment.

_____ _____
Witness Patients Signature Date

_____ _____
Witness Signature of Parent/Guardian Date

Smile Shapers Dental

Appointment Policy

We require at least 24 hour notice, to make changes to a scheduled appointment. Appointment changes without 24 hours prior notice are subject to a $40 fee. As a courtesy to our patients we confirm appointments 1-2 days prior to your appointment. To assist us in this, please give us a phone number where you can best be reached.....

Home # ( ) _____
Cell # ( ) _____
Work # ( ) _____
Email _____

Please come financially prepared to each appointment. Co-payment is due at date of service.

If you are required by your physician to be pre-medicated prior to dental treatments, please be sure the antibiotic is taken 1 hour prior to your scheduled appointments.

I understand the above stated Smile Shapers policy. In addition I understand that repeated failures to keep appointments without sufficient notice can lead to termination of Doctor-Patient relationship.

X_____ _____
Signature of Patient Date

Smile Shapers
Family & Cosmetic Dentistry

FINANCIAL POLICY

Our philosophy is to make our patients lives healthier and more comfortable by providing *High Quality, Compassionate Dental Care*.

Smile Shapers Dental is committed to providing you with the best possible dental care. To do this, it is important that we do not allow your dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your dental needs. We assume that you are as concerned as we are about maintaining your excellent health.

Due to many changes in insurance policies, it is no longer an easy task to interpret each patient's individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, please be aware that it is the patient's responsibility to know your coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs.

As a courtesy to our patients, we will bill your insurance carrier for any services rendered. However, we do require that any uncovered services, deductibles or co-payments be paid in full at each appointment. Co-payments are estimated based on the information we have obtained from your insurance carrier. We do not guarantee any estimates and should your plan pay or state less than expected, you are fully responsible. We take no responsibility for any denials by dental plans.

In addition, to avoid any confusion or misunderstandings, the following simply states our financial policy regarding payment for professional services.

- Payment is due, in full, as treatment is rendered. Cash, check, Visa, MasterCard, American Express, or Discover card is accepted.
- Payment plans are available through Care Credit. Interest free and extended terms are available. Ask our office staff for more information or an application.
- Balances over 30 days are subject to a 1.5% interest rate (minimum of $5.00) per month.
- Parent/Guardian that brings a minor in for professional services must accept all financial responsibility.
- There is a service charge on all returned checks.
- After 90 days we reserve the right to send a patient balance to collections and additional administrative fees will be applied (35% of the balance).

I have read and fully understand the financial policy outlined above. In addition, I understand that my failure to comply with this policy may result in my account being turned over for collections.

_____ _____

Signature of Patient, Parent/Guardian Date

Smile Shapers
Family & Cosmetic Dentistry

Patient Consent to Receive Mail, E-mail, and/or Telephone messages

_____

Please Print (Last Name) (First Name) (M.I.) (Date)

I agree that the practice may communicate with me electronically at the following addresses:

_____ _____

Phone Number E-Mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Yes____ No____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail? Yes____ No____

I give permission to share appointment information with the person named below:

_____	_____	_____
Name	**Phone Number**	**Email Address**
_____	_____	_____
Name	**Phone Number**	**Email Address**

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Privacy Practices and I understand what I have received.

_____

Signature of patient/Parent or Legal Guardian Date

If signed by other than patient, please specify relationship to patient: _____