SMILE DESIGN CENTRE

Today's date:

Registration and Medical History

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.		Marital status Single / Married / Divorced / Separated / Widowed	

Please send appointment reminders to:	Mobile phone #: _____ ☐ Yes ☐ No	Email Address: _____ ☐ Yes ☐ No	Birth date: / /	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

I chose this office because (please check all that apply): ❑ _____ ❑ Insurance Plan ❑ Radio ❑ Family ❑ Friend ❑ Close to home/work ❑ Billboard ❑ TV

Other family members seen here:

INSURANCE INFORMATION

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize Smile Design Centre or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐
9. Have you ever taken Biophosphates (i.e. Fosamax, Boniva, Actonel, etc.)?	☐	☐
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have or have you had any of the following?	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Low Blood Pressure	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Chest Pains	☐	☐
Stroke	☐	☐
Heart Trouble	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Joint Replacement or Implant	☐	☐
Tuberculosis	☐	☐
Hepatitis/Jaundice	☐	☐
Liver Disease	☐	☐
Aids or HIV Infection	☐	☐
Emphysema	☐	☐
Easily Winded	☐	☐
Hay Fever/Allergies	☐	☐
Respiratory Problems	☐	☐
Leukemia	☐	☐
Cancer	☐	☐
Radiation Therapy	☐	☐
Fainting/Seizures	☐	☐
Epilepsy/Convulsions	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Kidney Diseases	☐	☐
Thyroid Problem	☐	☐
Arthritis	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Other	☐	☐

PATIENT DENTAL HISTORY

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐
16. Have you had cold sores in the past frequently?	☐	☐

AUTHORIZATION/RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient/parent (if minor)

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name	Middle Initial	Last Name	Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○
Height	Feet / Inches	**Neck Size**	Inches	Neck Size: +2 Male ≥16.5, +2 Female≥15.0
Date of Birth	Month / Day / Year	**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

Co-morbidities +1 for each Yes response

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	

Welcome to the Smile Design Centre! Thank you for choosing our practice for all of your dental needs *and* wants. Dental treatment is very important to your health and should not be postponed by financial concerns, so our collection policy is based on an open and honest discussion of our pricing and financial arrangements made in advance. Our philosophy is to make dentistry affordable to everyone, and we hope this helps you make us your dental home. For your convenience, we offer the following financial arrangements:

1. We accept **Visa**, **MasterCard**, **Discover**, **American Express**, and **Care Credit**.
2. An **8%** discount will be given for check or cash payment **3 days prior** to beginning any treatment that is over $250.
3. A **5%** immediate payment courtesy will be given for treatment over $250 when paid in full by cash or check **on the day of treatment.**

DENTAL INSURANCE:

We are considered an in-network provider for most PPO networks. Please ask a business team member to confirm participation with your individual policy.

FINANCIAL RESPONSIBILITY:

I/We agree and personally guarantee, in consideration of services and materials provided by Smile Design Centre to be responsible for payment in full of the dental bill. Collection procedures began by statement sent in 20 day cycle, followed by telephone activity at 60 days delinquent, and if the account reaches 90 days past due Transworld Systems (third party collection agency) promptly seizes the account. In the event that this matter is turned over to Transworld Systems, I expect to pay a flat rate of $50 in addition to the original amount. ACKNOWLEDGEMENT SIGNATURE _____

A PATIENT'S APPOINTMENT RESPONSIBILITY:

We make every effort to schedule your treatment at a convenient time. When your dental needs are diagnosed, if left alone over time, they *only* get worse. Therefore, it is very important that you keep your appointment as scheduled. Most of our patients are very understanding of how short notice appointment changes affect other patients of our practice, therefor we do request a 48-hour notice if you need to make appointment changes. Our policy concerning canceled or failed appointments is as follows:

- A patient with an appointment must call at least **48 BUSINESS hours** in advance prior to canceling or rescheduling their appointment time.
- Short notice(less than 48 hours) cancellations and/or rescheduling can result in a charge of $50, which will be billed directly to you.
- With two short notice appointment changes within a 12-month period of time, we will require you to hold your next appointment on a credit card.
- After the **THIRD** cancellation or failed appointment within a 12-month period of time, we will provide treatment 30 days on an emergency basis only. At that time, we will give you the opportunity to find another dental office.

_____ _____ _____

Responsible Party's Signature Date Authorized Signature

AUTHORIZATION FOR INSURANCE SUBMISSION, HIPPA POLICY RECIEPT

I hereby authorize the Smile Design Centre to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents. I hereby authorize payment of medical or dental benefits otherwise payable to me, directly to the Smile Design Centre.This "Signature On File" will be valid from this date. A photocopy of this document may act as an original. I understand by signing this form, I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Your office will continue to use my health information in some of these ways: by calling me by my first and last name from your waiting room, by mailing me reminder appointment cards with reason for visit, and by calling to confirm appointments, as described in our Notice of Privacy Practices.

OTHER ADULT(S) WHOM APPOINTMENT AND/OR PROTECTED HEALTH INFORMATION MAY BE RELEASED

_____

Name(s) for information to be released (if none, please specify)

I have received a copy of this office's Notice of Privacy Practices on this date.

_____ _____

Signature Date

PARENT AND GUARDIANS OF MINOR CHILDREN ONLY

I, being the parent or guardian, do hereby request and authorize the dental staff to perform necessary dental services for my child, but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also do hereby authorize the following named adults' authority to make dental care decisions and receive information for the above-mentioned minor in my absence:

_____ _____

Signed Date