Welcome to Modern Smiles Dental Care

Thank you for choosing our office. At Modern Smiles we strive to build long-term relationships with our patients where we provide quality, consumer-friendly dental services utilizing the latest dental technology that the whole family can value and afford in a safe and happy environment.

Patient Information (Confidential):

Name _____ (If child, parent/guardian name)_____
Last name *First name* *Initial*

Birthdate_____ Sex ___ Age _____ Soc. Sec. #_____
Home Address _____ City _____ State_____ Zip _____
Home Phone _____ Work Phone _____ Cell phone_____
E-Mail _____ Drivers License # _____

How did you hear about our practice? _____
Employer _____ Occupation_____ How long there? _____ May we call? _____
Employer Address _____ City _____ State _____ Zip _____
Spouse's Name (Or other parent/guardian) _____ Soc. Sec. # _____
Spouse's Employer _____ Occupation_____ How long there?_____ May we call? _____
Spouse's Employer Address _____ City _____ State _____ Zip _____

If patient is a student: Name of school/college: _____ City & State _____ Full time or part time?____

Primary Insurance:

Name of Insured _____
Birthdate _____ Relationship to patient _____
Address (if different from patient) _____
Dental Insurance Co. _____ Phone _____
Social Security #_____ Subscriber ID # _____
Group, Contract or Local or union # _____

Additional Insurance:

Name of Insured _____
Birthdate_____ Relationship to patient _____
Address (if different from patient) _____
Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID # _____
Group, Contract or Local or union # _____

In Case of Emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you: _____ Phone #'s (home, work, cell) _____

Notice of Privacy Practices & Authorization:

By signing this form, you consent that you have read our posted notice of Privacy Practices (HIPPA) and understand it completely. I understand that I am authorizing the release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office.

I understand that I (or said dependent) have insurance coverage that will be assigned to the office for billing and payment. I understand that I am financially responsible for all charges whether they are paid by insurance or not, as well as any additional collection costs for balances payable over 60 days. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize the use of this signature on all insurance submissions/claims.

I understand that appointment times are specifically scheduled for ideal patient care and that last-minute cancellations and no-shows are subject to a $50 per occurrence fee. I understand that after several missed appointments the doctor may dismiss me as a patient of the practice.

I authorize Modern Smiles Dental Care to confirm my appointments via phone, email and text messaging confirmations. I further authorize being contacted about special services, events of new health information on behalf of the dental office via phone message, text message, and email.

I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature _____ Date_____
Patient or Responsible Party

Dental History

Patient Name: Age _____ Date _____

Reason for seeking care today: Exam Cleaning Specific Problem _____
(Please describe)

Please check all that apply:

- ❑ Toothache
- ❑ Broken filling or tooth
- Sensitivity to:
  - ❑ Cold
  - ❑ Hot
  - ❑ Sweets
  - ❑ Chewing
- ❑ Food catches
- ❑ Loose teeth
- ❑ Floss breaks easily or hurts
- ❑ Bite or teeth have shifted
- ❑ Often bite cheeks
- ❑ Frequent dry mouth
- ❑ Concerned about breath
- ❑ Unhappy with previous dental work
- ❑ Gums bleed
- ❑ Gums tender
- ❑ Growths, sores
- ❑ Cold sores, fever blisters
- ❑ Cracked, chapped lips
- ❑ Bad taste in mouth
- ❑ Sinus problems
- ❑ Mouth breathe — Difficulty breathing through nose
- ❑ Dry or strained eyes
- ❑ Shoulder, neck or headaches
- ❑ Clench or grind teeth
- ❑ Jaw joint pain
- ❑ Clicking or popping of joint.
- ❑ Unable to open mouth wide
- ❑ Jaw gets tired easily.
- ❑ Hold things between teeth (Pipe, pencil, nails, pins)
- ❑ Bite fingernails
- ❑ Unusual habits with teeth
- ❑ Wore braces
- ❑ Previous gum treatment
- ❑ Previous bite treatment

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed)_____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist? _____

Did your parents have difficulties with their teeth or dental treatments? _____

Medical History

Physicians Name: _____

City: _____ Phone_____

Have you been hospitalized for any reason? Please describe:

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed)

_____

_____

Are you taking or have ever taken Bisphosphonates? If yes, name of drug and how long taken. _____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, jewelry, metal, tetracycline, food allergies, other? _____

_____

Do you smoke? How much/day? _____

Pregnant? Due date _____ Are you nursing? _____

Are you seeing a physician now or planning to see one for any reason?

Please explain: (Continue on back of form if needed)

_____

_____

_____

_____

Please check all that apply:

- ❑ Previous injury to head or neck
- ❑ Heart problem
- ❑ Heart Attack
- ❑ Angina, chest pain
- ❑ Heart murmur
- ❑ Scarlet, Rheumatic fever
- ❑ Mitral valve prolapse
- ❑ Irregular heartbeat
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Artificial joint, bones, valves
- ❑ Neurological disorders
- ❑ Depression
- ❑ T8
- ❑ Diabetes
- ❑ HIV or AIDS
- ❑ Kidney problem
- ❑ Liver problem, jaundice
- ❑ Cirrhosis, Hepatitis
- ❑ Cancer, Radiation, Chemotherapy
- ❑ Respiratory problem
- ❑ Bloody, persistent cough
- ❑ Asthma, Emphysema
- ❑ Anemia
- ❑ Sickle cell disease
- ❑ Osteoporosis (list meds)

_____

- ❑ Psychotic problems
- ❑ STD
- ❑ Digestive problem, ulcer
- ❑ Thyroid disease
- ❑ Glaucoma
- ❑ Bleed or bruise easily
- ❑ Stroke
- ❑ Epilepsy or Seizures
- ❑ Parkinson's
- ❑ Alzheimer's
- ❑ Back problem
- ❑ Hives, rash
- ❑ Dry eyes
- ❑ Colitis
- ❑ Sinus Problems
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Snoring, sleep apnea
- ❑ No energy
- ❑ Fainting or dizzy
- ❑ Unexplained weight loss
- ❑ Chewing tobacco
- ❑ Drug or alcohol addiction
- ❑ 2 or more social drinks/day
- ❑ Anxiety or nervous disorder
- ❑ Insomnia
- ❑ Contact lenses
- ❑ Herpes/Fever Blisters

Any other illnesses not checked above? _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ❑ Yes ❑ No

Please rate the following indicators of your daily stress level: 1-10 : (1 = low, 10 = high)

Overworked, too busy, pressured Feel frustrated Get upset or "snap" easily Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date _____

Dentist' Signature _____ Date _____