MEQUON SMILE DESIGN

PATIENT INFORMATION

Patient Name	Preferred Name	Birthdate
Address	City / State / Zip	
Home Phone	Cell Phone	Work Phone
E-mail	SS# (some insurances require for verification)	

Best Way to contact you ☐ Home ☐ Cell ☐ Work ☐ E-mail

Family Status ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed ☐ Minor

*****NEW PATIENTS ONLY****

Referred By ☐ Insurance ☐ Google ☐ Another Patient _____ ☐ Other

EMERGENCY CONTACT

Name	Relationship	Phone
Who is responsible for this account		

EMPLOYER

Patient Employer	Occupation		
Address	City	State	Zip

DENTAL INSURANCE

Dental Insurance ☐ Yes ☐ No *(if yes, please fill out insurance information below)*

Dental Insurance Carrier	ID # or SS#

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Responsible Party Signature

_____ Relationship to patient

_____ Date

MEQUON SMILE DESIGN

Patient First Name _____ Patient Last Name _____ Date _____

MEDICAL HISTORY

Although dental personnel primary treat the area in and around your mouth, you mouth is apart of your entire body, health problems that you may have, or medication.

Are you currently under a physicians care | ☐ Yes ☐ No
Do you have a history of osteopenia, osteoporosis or other bone disease | ☐ Yes ☐ No
Have you ever had surgery | ☐ Yes ☐ No
Have you ever had to take a pre-med | ☐ Yes ☐ No
Are you or have you in the past been treated with Bisphosphonates for the treatment of bone denisity, metastatic cancer, or Pagets disease | ☐ Yes ☐ No
Are you or will you be having treatment or impeding surgery that could possibly affect you dental treatment | ☐ Yes ☐ No

WOMEN, Are you currently: ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contracptives

ALLERGIES, *check all that apply*

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Ibuprofen
☐ Tylenol
☐ Local Anesthetic
☐ Penicillin
☐ Other Antibiotics
☐ No know Allergies
☐ Codeine
☐ Iodine
☐ Food Allergies
☐ Sulfa
☐ Latex
☐ NSAIDS

List any additional allergies that may not be listed | _____

MEDICATIONS, *please list the medications you are currently taking* |

_____ _____
_____ _____
_____ _____

Indicate which of the following you have had or have at present, by checking the *"YES"* or *"NO"* box.

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV	☐	☐	Dizziness Fainting	☐	☐	MI/heart attack
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Neurological disease
☐	☐	Arthritis, Rheumatism	☐	☐	Elevated Cholesterol	☐	☐	Pacemaker
☐	☐	Artificial heart valves	☐	☐	Generalized anxiety	☐	☐	Psychiatric care
☐	☐	Artificial joints	☐	☐	GI Disorders	☐	☐	Radiation treatment
☐	☐	Asthma	☐	☐	Head Injuries	☐	☐	Respiratory problems
☐	☐	Autoimmune disorder	☐	☐	Head and neck cancer	☐	☐	Rheumatism
☐	☐	Back problems	☐	☐	Headaches	☐	☐	Rheumatic fever
☐	☐	Blood disease	☐	☐	Heart murmur	☐	☐	Scarlet fever
☐	☐	Diabetes or Family History	☐	☐	Heart disease	☐	☐	Sinus problems
☐	☐	CPAP/sleep disorder	☐	☐	Heart stent	☐	☐	Skin rash
☐	☐	Cancer	☐	☐	Hepatitis (type ___)	☐	☐	Special Diet
☐	☐	Chemical dependency	☐	☐	Herpes	☐	☐	Stroke
☐	☐	Chemotherapy	☐	☐	High blood pressure	☐	☐	Swollen neck glands
☐	☐	Circulatory problems	☐	☐	Jaundice	☐	☐	Smoking
☐	☐	Clotting disorder	☐	☐	Jaw pain	☐	☐	Tonsillitis
☐	☐	C-Difficile	☐	☐	Joint replacement	☐	☐	Tuberculosis
☐	☐	Congenital heart disease	☐	☐	Kidney disease	☐	☐	Tumors
☐	☐	Cortisone treatments	☐	☐	Liver disease	☐	☐	Thyroid problems
☐	☐	Diabetes or family history	☐	☐	Low blood pressure	☐	☐	Ulcer
☐	☐	Mitral valve prolapse	☐	☐	Venereal disease			

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Patient First Name _____ Patient Last Name _____ Date _____

DENTAL HEALTH HISTORY

DENTAL INFORMATION

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name | _____

How long were you a patient there | _____

Date of most recent exam an cleaning | _____

Date of most recent x-rays | _____

I routinely see my dentist every | ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

On a Scale from 1 - 10, with 10 being the highest rating |

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Are you fearful of the dentist? ..... Yes or No

If yes, how fearful?..... 1 2 3 4 5 6 7 8 9 10

What is your immediate concern | _____

PERSONAL HISTORY, *Check all that apply*

- ☐ Had an unfavorable dental experiene
- ☐ Had/ have braces, orthodontic treatment
- ☐ Had complications from past dental treatment
- ☐ Had your bit adjusted
- ☐ Had trouble getting numb
- ☐ Have / had any teeth removed
- ☐ Had any reactions to local anesthetic
- ☐ Fear or Anxitey about Dental Treatment

SMILE CHARACTERISTICS, *Check all that apply*

- ☐ Make my teeth whiter
- ☐ Close space / gaps that bother me
- ☐ Replace missing teeth
- ☐ Dissatisfied with appearance of my teeth
- ☐ Make my teeth straighter
- ☐ Repair chipped teeth
- ☐ Have a smile make over

TOOTH, STRUCTURE, *Check all that apply*

- ☐ Cavities in the past 3 years
- ☐ Dry Mouth
- ☐ Chipped tooth
- ☐ Dental Implants
- ☐ Root Canals
- ☐ Difficulty swallowing food
- ☐ Sensitivity to Hot Cold Sweets
- ☐ Dentures or Partials
- ☐ Crowns
- ☐ Loose Teeth

BITE AND JAW JOINT, *Check all that apply*

- ☐ Jaw Joint Pain
- ☐ Uncomfortable when I bite my teeth
- ☐ Teeth crowding
- ☐ Clicking or popping of the Jaw
- ☐ Difficulty opening and chewing
- ☐ Wear or wear a bite appliance
- ☐ Chewing problems
- ☐ Grinding or clenthing teeth
- ☐ Develping spaces
- ☐ Sleep problems
- ☐ Frequent headaches
- ☐ Jaw Surgery

GUM AND BONE, *Check all that apply*

- ☐ Bleeding, Swollen or Irritated Gums
- ☐ Lost bone around your teeth
- ☐ History of periodontal disease in your family
- ☐ Experience a burning sensation in your mouth
- ☐ Periodontal Disease or Gum Treatments
- ☐ Unpleasent odor or taste in mouth
- ☐ Gum recession

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OFFICE POLICIES

PAYMENTS (Initial)_____

Payment is expected the day services are rendered. In the event of a default of payment or any balance not covered by insurance that is 45 days past due, your account will be turned over to our collection agency. The responsible party will pay all reasonable court costs and attorney fees. We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we do offer several alternative payment programs for your convenience, including, **Check, Credit Cards** *(MasterCard, Visa, Discover, and American Express),* Care Credit and Sunbit *(Healthcare financing option)* some plans with no interest. **Please note any balances that are over 30 days past due will accrue a 1.5% interest fee.**

I understand that any fee estimate for this dental care can only be extended for six (6) months from the date of the patient's examination. In consideration for the professional services rendered to me by this practice, I agree to pay for the charges for the services at the time of treatment or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to by me in wiring, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if a suit is instituted hereunder. **I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.**

INSURANCE (Initial)_____

If you have insurance, we will gladly process your forms. Our only request is that you pay your estimated portion when services are rendered. Please remember that our contract for payments is with you and your insurance carrier. **If you have provided us with your complete insurance information, we will bill your insurance as a courtesy to you.**

CANCELLATIONS/MISSED APPOINTMENTS (Initial)_____

We ask that you provide us a forty-eight (48) hours advanced notice for cancellation of appointments. We reserve the right to collect a deposit fee for your next appointment if you continue to cancel, reschedule, or miss appointments.

FAMILY POLICY (Initial)_____

To schedule 3 or more family members on the same day, we require a $50.00 deposit fee for each family member.

APPOINTMENTS 70 MINUTES OR MORE (Initial)_____

To reserve an appointment, we require that you pay 50% of your patient portion before the appointment to reserve that time. We require two (2) business days' notice for changes to treatment appointments. If you are not able to keep an appointment, as per these guidelines, your reservation fee will be non-refundable.

E-MAIL AND TEXT MESSAGING (Initial)_____

Due to the changing world of healthcare and technology, Mequon Smile Design has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below. Mequon Smile Design believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. Mequon Smile Design does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Please check one:

- ☐ Yes, please sign me up to receive e-mail and text messaging communications from Mequon Smile Design
- ☐ I do not wish to be contacted via e-mail. (Text messaging only)
- ☐ I do not wish to be contacted via text messaging. (E-mail only)
- ☐ I do not wish to be contacted by either text messaging or e-mail.

CONSENT FOR INTERNET COMMUNICATIONS (Initial)_____

I grant my permission to the dental practice to upload and store confidential information (including account information, appointment information, and clinical information) **to the secured website for the dental practice.**

I understand that, for security purposes, the site requires a used ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality.

I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make sure of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws.

I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with its operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf.

I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the website for the dental practice and grant the dental practice permission to securely upload my patient information to the website.

HIPAA ACKNOWLEDGEMENT

(Initial)_____

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been take in reliance on an authorization I have signed.

I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name	Patient Signature	Date

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