



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	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> E-mail
Family Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor

*****NEW PATIENTS ONLY*****			
Referred By	<input type="checkbox"/> Insurance	<input type="checkbox"/> Google	<input type="checkbox"/> Another Patient _____ <input type="checkbox"/> Other

EMERGENCY CONTACT		
Name	Relationship	Phone
Who is responsible for this account		

EMPLOYER			
Patient Employer	Occupation		
Address	City	State	Zip

DENTAL INSURANCE	
Dental Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, please fill out insurance information below)</i>
Dental Insurance Carrier	ID # or SS#

ASSIGNMENT & RELEASE		
<p>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.</p>		
_____ Responsible Party Signature	_____ Relationship to patient	_____ Date



Medical History

Are you currently under a physicians care? Yes____ No ____

If yes, who is your provider? _____

Have you ever had surgery? Yes____ No ____

If yes, what did you have done and when? _____

Have you ever had to take a pre-medication or an antibiotic prior to a dental appointment?

Yes____ No ____ If yes, why? _____

Do you have a history of osteopenia, osteoporosis, or any other bone disease? Yes____ No ____

If yes, what? _____

Are you or have you in the past been treated with Bisphosphonates for the treatment of bone density, metastatic cancer, or Paget's Disease? Yes____ No ____

If yes, what and when? _____

Are you or will you be having treatment or impending surgery that could possibly affect your dental treatment? Yes____ No ____

If yes, when and for what? _____

Please list any medications that you are currently taking:

Are you allergic to any of the following?

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Acrylics | <input type="checkbox"/> Latex | <input type="checkbox"/> Barbiturates
(sleeping pills) |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> NSAIDS |

- No Known allergies
- Other allergies please list:

Do you have or have you ever had, any of the following conditions?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> ADD or
ADHD | <input type="checkbox"/> Alzheimer's
Disease | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Auto-immune
Disorder | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Artificial
Heart Valve | <input type="checkbox"/> Autism | <input type="checkbox"/> Artificial
Joint | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood
Disease | <input type="checkbox"/> Breathing
Problem | <input type="checkbox"/> Back
Problems | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemothera-
py or
Radiation
Treatment | <input type="checkbox"/> CPAP/Sleep
Disorder | <input type="checkbox"/> Clotting Disorder |
| <input type="checkbox"/> C-Difficile | <input type="checkbox"/> Circulatory
Problems | <input type="checkbox"/> Cortisone
Medicine | <input type="checkbox"/> Chemical
Dependency |
| <input type="checkbox"/> Cold
Sores/Fever
Blisters | <input type="checkbox"/> Congenital
Heart
Disorder | <input type="checkbox"/> Dizziness or
Fainting | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Elevated
Cholesterol | <input type="checkbox"/> Epilepsy or
Seizures | <input type="checkbox"/> Excessive
Bleeding |

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Generalized Anxiety | <input type="checkbox"/> GI Disorders | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Head and Neck Cancer | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Heart Troubles/Disease |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hepatitis B or C | | | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> None of the following conditions | | |

Other condition that wasn't listed. Please list:

Female Only Conditions

- | | | |
|---|----------------------------------|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Nursing | <input type="checkbox"/> Taking Oral Contraceptives |
| <input type="checkbox"/> Trying to get pregnant | <input type="checkbox"/> None | |

I confirm that all information completed is accurate and understood. Please sign below to acknowledge.

Signature

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 and 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*

- | | |
|---|---|
| <input type="checkbox"/> Had an unfavorable dental experience | <input type="checkbox"/> Had trouble getting numb |
| <input type="checkbox"/> Had/ have braces, orthodontic treatment | <input type="checkbox"/> Have / had any teeth removed |
| <input type="checkbox"/> Had complications from past dental treatment | <input type="checkbox"/> Had any reactions to local anesthetic |
| <input type="checkbox"/> Had your bit adjusted | <input type="checkbox"/> Fear or Anxiety about Dental Treatment |

SMILE CHARACTERISTICS, *Check all that apply*

- | | |
|---|---|
| <input type="checkbox"/> Make my teeth whiter | <input type="checkbox"/> Make my teeth straighter |
| <input type="checkbox"/> Close space / gaps that bother me | <input type="checkbox"/> Repair chipped teeth |
| <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Have a smile make over |
| <input type="checkbox"/> Dissatisfied with appearance of my teeth | |

TOOTH, STRUCTURE, *Check all that apply*

- | | |
|---|---|
| <input type="checkbox"/> Cavities in the past 3 years | <input type="checkbox"/> Difficulty swallowing food |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Sensitivity to Hot Cold Sweets |
| <input type="checkbox"/> Chipped tooth | <input type="checkbox"/> Dentures or Partials |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Crowns |
| <input type="checkbox"/> Root Canals | <input type="checkbox"/> Loose Teeth |

BITE AND JAW JOINT, *Check all that apply*

- | | |
|---|--|
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Chewing problems |
| <input type="checkbox"/> Uncomfortable when I bite my teeth | <input type="checkbox"/> Grinding or clenching teeth |
| <input type="checkbox"/> Teeth crowding | <input type="checkbox"/> Developing spaces |
| <input type="checkbox"/> Clicking or popping of the Jaw | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Difficulty opening and chewing | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Wear or wear a bite appliance | <input type="checkbox"/> Jaw Surgery |

GUM AND BONE, *Check all that apply*

- | | |
|--|--|
| <input type="checkbox"/> Bleeding, Swollen or Irritated Gums | <input type="checkbox"/> Periodontal Disease or Gum Treatments |
| <input type="checkbox"/> Lost bone around your teeth | <input type="checkbox"/> Unpleasant odor or taste in mouth |
| <input type="checkbox"/> History of periodontal disease in your family | <input type="checkbox"/> Gum recession |
| <input type="checkbox"/> Experience a burning sensation in your mouth | |

Office Policies

- Payments * by checking you are initialing * - 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 90 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 (Healthcare financing option) some plans with no interest. Please not any balances that are over 30 days past due will accrue a 1.0% 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 writing, 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 - * by checking you are initialing * - 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 - * by checking you are initialing * - We know that your time is valuable and so is ours so we ask that you provide us a forty-eight (48) hours advanced notice for cancellation of appointments. We reserve the right to collect a \$100 fee for the last minute cancelled appointment or no call no show, this would be non-refundable. If you continue to cancel, reschedule, or miss appointments you will be asked to pay a \$100 appointment deposit. If the appointment is failed this deposit is non-refundable.
- Self Pay Patients - * by checking you are initialing * - We ask that you put \$100 down to hold your appointment with our office and pay the remaining balance day of service. If the appointment is failed this deposit is non-refundable.
- Friday Appointments - * by checking you are initialing * - We ask that all Friday patients put down at least \$50 for an appointment hold. If the appointment is failed an additional \$50 will be charged, totally \$100. The total \$100 being non-refundable.

- Family Policy - *by checking you are initialing* - To schedule 3 or more family members on the same day, we require a \$50 deposit fee for each family member.
- Appointments 70 minutes or more - * by checking you are initialing * To reserve an appointment, we require that you pay 50% or \$100 towards of your estimated 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.
- Email and Text Messages - * by checking you are initialing * - 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, email addresses, and/or telephone numbers of patients with any other company, with our patients.
- Consent for Internet Communications - * by checking you are initialing * - 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 the dental office to use a user ID and password. I also understand the dental practice and I am 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 RECIEVED 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.

- HIPPA Acknowledgement - *by checking you are initialing* - 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.

I confirm that all information above is understood. Please sign and date to acknowledge.

Signature

Date



**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE
OF HEALTH INFORMATION**

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____ Birthday: _____

I. My Authorization

I authorize *Mequon Smile Design* to use or disclose all of my health information until I leave the practice.

The above party may disclose this health information to the following recipient:

Name _____

Relationship _____

Phone _____ Email _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor, the guardian please complete the following:

Signature of Guardian: _____ Date: _____