Natural Smiles

Excellence in Cosmetic & General Dentistry

## Getting to Know You

Name: _____ Date: _____

What would you like to be called? _____

Please describe the reason for your visit today? _____

_____

Are you having any problems now? ☐ Yes ☐ No If so what? _____

_____

Are you apprehensive about dental treatment? ☐ Yes ☐ No

When was your last check up? _____

Who is your regular or previous dentist? _____

**Have you noticed or has any dentist or hygienist said that you have (Check those that apply)**

| | | |
|---|---|---|
| ☐ Gum Disease | ☐ Lip or cheek biting | ☐ Grind your teeth |
| ☐ Loose or Broken Teeth | ☐ Clicking or popping jaw | ☐ Bad breath |
| ☐ Food collection between teeth | ☐ Jaw pain or tiredness | ☐ Pain around ear |
| ☐ Sore, blisters, or growths | ☐ Dry mouth | ☐ Headaches |

**Sensitivity to:** ☐ Cold ☐ Hot ☐ Sweets ☐ When biting or chewing

Do you wear dentures or partials? Yes No

How happy are you with your smile? Please circle (10 Highest/1 Lowest): 1 2 3 4 5 6 7 8 9 10

What 3 things would you change if you could?

1. _____ 2. _____ 3. _____

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## Patient Registration

Patients Name: First: _____ Last: _____ MI: ___ Sex: M F Birth Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Work: _____ Home: _____ Cell: _____

Email Address: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer: _____ Occupation: _____

## Referral Source

Who referred you to our office/ How did you hear about our office? _____

## Responsible Party

Responsible Party's Name: First: _____ Last: _____ MI: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Work: _____ Home: _____ Cell: _____

Email Address: _____

Birth Date: _____ SSN# _____

Relationship to Patient: _____

## Dental Insurance Information

**Primary Dental Insurance**

Name of Insured _____ Insurance Company Name _____
Insured's Birthdate _____ Address _____
Insured's SS# _____ City _____ State _____ Zip _____
Insured's ID# _____ Phone# _____
Insured's Employer _____ Group# _____
Relationship to Patient _____

**Secondary Dental Insurance**

Name of Insured _____ Insurance Company Name _____
Insured's Birthdate _____ Address _____
Insured's SS# _____ City _____ State _____ Zip _____
Insured's ID# _____ Phone# _____
Insured's Employer _____ Group# _____
Relationship to Patient _____

I hereby authorize assignment of my insurance rights and benefits to Natural Smiles for services rended.
I fully understand I am solely responsible for any balance not paid by my insurance company.

Signature: _____

## In Event of Emergency

Whom should we contact? _____ Relationship: _____ Phone: _____

Who is your medical doctor? _____ Medical doctor's phone# _____

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## Medical History

Patient's Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | | |
|---|---|---|---|
| Are you under a physicians care now? | ☐ Yes | ☐ No | If yes, please explain _____ |
| Have you ever been hospitalized or had a major operation? | ☐ Yes | ☐ No | If yes, please explain _____ |
| Have you ever had a serious head or neck injury? | ☐ Yes | ☐ No | If yes, please explain _____ |
| Are you taking any medications, pills, or drugs? | ☐ Yes | ☐ No | If yes, please explain _____ |
| Do you take, or have you taken Phen-Fen or Redux? | ☐ Yes | ☐ No | _____ |
| Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphates? | ☐ Yes | ☐ No | _____ |
| Are you on a special diet? | ☐ Yes | ☐ No | |
| Do you use tobacco? | ☐ Yes | ☐ No | |
| Do you use controlled substances? | ☐ Yes | ☐ No | |

**Women: are you**

Pregnant/Trying to get pregnant? ☐ Yes ☐ No  Taking oral contraceptives? ☐ Yes ☐ No  Nursing? ☐ Yes ☐ No

**Are you allergic to any of the following?**

☐ Aspirin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Other, If yes, please explain: _____

☐ Penicillin ☐ Local Anesthetics ☐ Metal ☐ Sulfa Drugs

**Do you have, or have you had any of the following?**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Cortisone Medication | Yes | No | Hemophilia | Yes | No | Radiation Treatment | Yes | No |
| Alzheimer's Disease | Yes | No | Diabetes | Yes | No | Hepatitis A | Yes | No | Recent Weight Loss | Yes | No |
| Anaphylaxis | Yes | No | Drug Addiction | Yes | No | Hepatitis B or C | Yes | No | Renal Dialysis | Yes | No |
| Anemia | Yes | No | Easily Winded | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No |
| Angina | Yes | No | Emphysema | Yes | No | High Blood Pressure | Yes | No | Rheumatism | Yes | No |
| Arthritis/Gout | Yes | No | Epilepsy or Seizures | Yes | No | High Cholesterol | Yes | No | Scarlet Fever | Yes | No |
| Artificial Heart Valve | Yes | No | Excessive Bleeding | Yes | No | Hives or Rash | Yes | No | Shingles | Yes | No |
| Artificial Joint | Yes | No | Excessive Thirst | Yes | No | Hypoglycemia | Yes | No | Sickle Cell Disease | Yes | No |
| Asthma | Yes | No | Fainting Spells/Dizziness | Yes | No | Irregular Heartbeat | Yes | No | Sinus Trouble | Yes | No |
| Blood Disease | Yes | No | Frequent Cough | Yes | No | Kidney Problems | Yes | No | Spina Bifida | Yes | No |
| Blood Transfusion | Yes | No | Frequent Diarrhea | Yes | No | Leukemia | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Breathing Problem | Yes | No | Frequent Headaches | Yes | No | Liver Disease | Yes | No | Stroke | Yes | No |
| Bruise Easily | Yes | No | Genital Herpes | Yes | No | Low Blood Pressure | Yes | No | Swelling of Limbs | Yes | No |
| Cancer | Yes | No | Glaucoma | Yes | No | Lung Disease | Yes | No | Thyroid Disease | Yes | No |
| Chemotherapy | Yes | No | Hay Fever | Yes | No | Mitral Valve Problems | Yes | No | Tonsillitis | Yes | No |
| Chest Pains | Yes | No | Heart Attack/Failure | Yes | No | Osteoporosis | Yes | No | Tuberculosis | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Heart Murmur | Yes | No | Pain in Jaw Joints | Yes | No | Tumors or Growths | Yes | No |
| Congenital Heart Disorder | Yes | No | Heart Pacemaker | Yes | No | Parathyroid Disease | Yes | No | Ulcers | Yes | No |
| Convulsions | Yes | No | Heart Trouble/Disease | Yes | No | Psychiatric Care | Yes | No | Venereal Disease | Yes | No |
| | | | | | | | | | Yellow Jaundice | Yes | No |

Have you ever had any serious illness not listed above? Yes No  If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature of Patient, Parent, or Guardian** _____ **Date** _____

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## Privacy Practices

I have received a copy of the Privacy Practices provided by Natural Smiles

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health Information to carry out treatment, payment activities, and healthcare operations.

Print name:_____ Date of Birth: _____

Email Address:_____ Social Security #: _____

Signature of Patient/Parent or Guardian:_____

Date: _____

My protected health information may be disclosed to:

- ☐ Self Only
- ☐ Spouse/Significant Other: _____ Phone #: _____
- ☐ Parent/Guardian: _____ Phone #: _____

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at any time by contacting: Lori Gregory Telephone: 502-893-5225 Email: Lori@naturalsmilesky.com

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

### NOTE TO OUR PATIENTS

Accounts are to be paid at time of service. We accept all dental insurance plans but may be classified as out of network. Please check with your insurance carrier. Our office will file your insurance claims. This does not transfer your financial obligation to your insurance company. Therefore, you are responsible for any outstanding balance and will pay 1½ percent service charge per month. Should your account go to collections, you agree to pay the collection cost and reasonable attorney fee.

Signature:_____Date_____

Missed appointment fee: The second time a patient does not show for an appointment, or cancels with less than 48 hours notice, a **$35.00 fee will be charged**. This fee must be paid before a new appointment is scheduled.

Signature:_____Date_____

Thank you,

Natural Smiles