PATIENT INFORMATION

Date_____ **Patient's Name** _____
First Last MI

Address _____
Street City Zip

Hm Ph (____)_____ **Wk Ph (____)**_____ **Cl (____)**_____ **SSN**_____-____-_____

I would like appointment reminders via (check boxes) ☐ **Email** _____ ☐ **Text** ☐ **mail**

Birthdate ____/____/____ **Sex M / F** **If patient is a minor, give parent/guardian's name** _____

Name of nearest living relative not living with you _____ **Relationship** _____

Relative's address _____ **Ph # (____)**_____

Emergency Contact _____ **Ph # (____)**_____

Responsible Party or Spouse Information

Name _____ **Relationship to Patient** _____
First Last MI

Hm Ph (____)_____ **Wk Ph (____)**_____ **Cl (____)**_____ **email** _____ _____

Mailing Address_____
Street City Zip

Insurance Information

Insured's Name _____ **Insured's SSN** _____-_____-_____

Relationship to Patient _____**Insured's Insurance ID #** _____ **Insured's Birthdate** ____/___/_____

Insurance Company _____ **Group #** _____

Insurance Co. Address _____ **Ph # (____)**_____

Insured's Employer _____ **Bus. Address** _____

Is insurance policy connected with your union? Yes / No Name of Union _____ **Local #** _____

Do you have dual coverage? Yes / No If yes, please fill out the following secondary insurance information:

Insured's Name _____ **Insured's SSN** _____-_____-_____

Relationship to Patient _____**Insured's Insurance ID #** _____ **Insured's Birthdate** ____/____/_____

Insurance Company _____ **Group #** _____

Insurance Co. Address _____ **Ph # (____)**_____

Insured's Employer _____ **Bus. Address** _____

We are honored that you have selected us to provide dental care to you and your family!

Whom may we thank for referring you to our office? _____

Dental and Health History

1. Dental history: *Circle*

Do you have any tooth …….. or mouth pain or discomfort? Yes No
Are your teeth sensitive to heat or cold? Yes No
Have you ever had a bad experience …. in a dental office? Yes No
Are you nervous about having dental … treatment? Yes No
Do your gums bleed when you brush? Yes No
Do you grind or clench your teeth? ….. Yes No

Date of last dental visit: _____
What are your dental concerns? _____
_____
How do you feel about the appearance of your teeth? _____
_____
What would you like us to know to better your dental treatment experience? _____
_____

2. Have you ever been hospitalized? … Yes No

3. Are you taking any medications, pills, drugs, or supplements? If so, please list: _____
_____

4. Are you taking or have you taken any osteoporosis / bisphosphonate medications (Boniva, Aredia, Fosamax, etc.)? ….. Yes No

5. Are you allergic to:

Latex …… Yes No
Metals …… Yes No
Penicillin …… Yes No

Foods …….. Yes No
list: _____

Others: _____ Yes No
_____

6. Do you have or have you had any of the following conditions:

Heart Failure ……	Yes	No	Glaucoma ……..	Yes	No	Epilepsy or Seizures ……	Yes	No
Heart Disease or Attack ……	Yes	No	Tobacco or Marijuana Use	Yes	No	Fainting or Dizzy Spells …….	Yes	No
Chest Pain ……	Yes	No	Persistent Cough ……	Yes	No	Nervousness / Anxiety …….	Yes	No
High Blood Pressure ……	Yes	No	Emphysema ……..	Yes	No	Psychiatric Treatment ……	Yes	No
Artificial Heart Valve ……	Yes	No	Tuberculosis (TB) ……	Yes	No	Sickle Cell Disease ……	Yes	No
Heart Defect or infection …..	Yes	No	Asthma ……	Yes	No	Hemophilia ……	Yes	No
Heart Pacemaker ……	Yes	No	Sinus Trouble ……	Yes	No	Special Diet ……	Yes	No
Heart Surgery ……..	Yes	No	Cancer	Yes	No			
Artificial Joints (Hip, Knee) …	Yes	No	Type: _____					
Anemia ……	Yes	No	Chemotherapy ……	Yes	No			
Stroke or TIA ……..	Yes	No	Radiation Therapy ……..	Yes	No			
Kidney Trouble ……	Yes	No	Drug Addiction ……	Yes	No			
Ulcers ……	Yes	No	Blood Transfusion ……..	Yes	No			
Eating Disorder ……..	Yes	No	STD:	Yes	No			
Diabetes ……	Yes	No	Type: _____					
Thyroid Disease ……..	Yes	No	HIV ……..	Yes	No			
Cosmetic Surgery ……..	Yes	No	HPV (Human Papaloma Virus)	Yes	No			
Cortisone Medication ……	Yes	No	Hepatitis A__, B__, C__ …	Yes	No			
Arthritis (Osteo or Rheumatiod)	Yes	No	Liver Disease or Jaundice …	Yes	No			
Pain in Jaw Joints ……	Yes	No	Cold Sores ……..	Yes	No			

For Doctor Use: _____
_____
_____
_____
_____
_____
_____
_____
_____

7. Do your ankles swell during the day or when you walk? …… Yes No
8. Do you use more than 2 pillows to sleep at night? …… Yes No
9. Do you have shortness of breath or chest pain after walking up a flight of stairs or several blocks? …… Yes No
10. Have you lost or gained more than 10 lbs. in the past year? …… Yes No
11. Do you ever wake up from sleep short of breath or have sleep apnea? …… Yes No
12. Do you have any diseases, conditions, or problems not listed? …… Yes No

FOR WOMEN ONLY

14. Are you pregnant? …… Yes No If yes, what month? _____ Are you taking birth control? Yes No

Consent and Authorization:

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I authorize Smile Art Dental doctors and staff to take X-rays, study models, photographs or other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medications, and therapy that may be indicated in connection with treatment and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embody certain risks

Patient Name: _____ Date: _____

Signature of Responsible Party: _____ Relationship to Patient _____

Dr. Signature: _____

Smile Art Dental
Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, DISCOVER CARD, AMERICAN EXPRESS.

WE OFFER AN EXTENDED PAYMENT PLAN THROUGH CARE CREDIT WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We cannot bill your insurance unless you give us your insurance information. We make our best effort to get you an accurate estimate of your out of pocket treatment cost. We will verify your insurance eligibility annually. Often, your exact cost cannot be determined until after insurance payment is received. Please inform us of any changes to your dental insurance or if you have recently been seen by another dentist so that we can provide you with the most accurate financial information.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your insurance coverage plan. The balance is still your responsibility whether your insurance pays or not.

All copays and deductibles are due <u>prior</u> to treatment.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates or necessity of treatment.

Minor Patients

The adult accompanying a minor and the parents are responsible for full payment. Unaccompanied minors must have a written consent for treatment from both parents or legal guardians. Without written consent, unaccompanied minors cannot be seen for treatment. Copays are due prior to treatment and can be taken over the phone if necessary.

Missed Appointments

Doctor, staff time and equipment are reserved for your appointments. Please help us serve you and our other patients better by keeping scheduled appointments. All appointment cancellations must be made at least 48 hours in advance to avoid a cancellation fee.

Thank you for understanding the Smile Art Dental Financial Policy. Please let us know if you have any questions or concerns. I understand and agree to this Financial Policy.

_____ _____

Responsible Party Signature Date

Additional Signatures

I have received a copy of the **Dental Materials Fact Sheet** as required by law.

_____

Signature Date

I have received a copy of Smile Art Dental's **Notice of Privacy Practices.**

_____

Signature Date

SMILE ART DENTAL

Dr. Joel Whiteman &Dr. Kristy Whiteman

Authorization for the release of Dental Records

I hereby authorize _____ to release the

Name of prior dentist or dental practice

information in the dental record of

_____

Patient Name DOB

to Joel Whiteman, DDS and Kristy Whiteman, DDS. Please mail/email documents to:

Joel Whiteman, DDS and Kristy Whiteman, DDS
3171 Riverside Blvd.
Sacramento, CA 95818

Email: smileartdentalxrays@gmail.com

To send digital documents, please call Dr. Whiteman's office: (916)446-0203

Any and all information may be released including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug an/or alcohol abuse and/or HIV tests, if any, except as specifically provided below.

Signed: _____

Patient or guardian signature Date