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 ..... Yes No
or mouth pain or discomfort?
Are your teeth sensitive to heat or cold? Yes No
Have you ever had a bad experience .... Yes No
in a dental office?
Are you nervous about having dental ... Yes No
treatment?
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 • Dental Materials Fact Sheet

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 prior 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. In the event that treatment may change during an appointment, we will make every effort to contact the responsible party. Changes to treatment may affect copay.

For Young Adults (ages 17+)
Acknowledgement for giving consent to my parents/guardian to be able to receive/access my treatment plans, dental/health history, make payments to my account, and be able to view/schedule my dental appointments.

_____	_____	_____
Patient Name	Patient Signature	Date

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 36 hours in advance to avoid a cancellation fee of $75.

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.

_____	_____
Responsible Party Signature	Date

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the Smile Art Dental Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

SMILE ART DENTAL

Consent Form for Use/Disclosure of the Patient Dental Health/Account Information

I, _____ (patient name) authorize Smile Art Dental to use/disclose my dental/health history, make payments to my account and be able to view/schedule my dental appointments to _____.

☐ Parent ☐ Guardian ☐ Significant other

I understand that I can limit my dental/health information to be used or disclosed noted below:

_____
_____
_____
_____

This authorization consent will be valid until I sign an additional form for the request of the person/guardian/significant other no longer be authorized to use or access my information.

Patient Name: _____ Date: _____

Patient Signature: _____

Signed by: ☐ Patient ☐ Parent ☐ Guardian ☐ Significant other

SMILE ART DENTAL

3171 Riverside Blvd., Sacramento, CA 95818
(916) 446-0203

Photograph Authorization

I hereby give my consent for Dr. Joel Whiteman and/or Dr. Kristy Whiteman to take photographs, slides and/or videotape of _____ (patient's name) face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry. I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record. I do not expect compensation, financial or otherwise, for the use of these images.

Please initial

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use. I consent to the use of my photographs, slides, and/or videotape **ONLY** for laboratory use.

_____ ***I DO NOT*** consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization.

I release and discharge Dr. Joel Whiteman and/or Dr. Kristy Whiteman business, organization, employees or agents from any and all claims or actions I have or may have relating to such use and publication.

_____ _____

Patient's or Legal Guardian's/Representative's Signature Date