Dr. Benjamin White, DDS

White Smiles General Dentistry

PATIENT INFORMATION

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential, subject to applicable laws.

PERSONAL

First Name _____ Middle Name _____ Last Name _____

Email _____ DOB ____/____/____ SSN _____

Home Phone # _____ Cell Phone # _____

Mailing Address _____ Billing Address (if different) _____

City, State, Zip _____ City, State, Zip _____

WORK

Employer _____ Occupation _____

Work Phone # _____

INSURANCE

Insurance Plan _____ Group Number _____

Subscriber Name _____ Subscriber ID _____

Subscriber SSN _____ Subscriber DOB _____

**Please allow the receptionist to make a copy of any insurance cards, or provide the information so that we may file any claims on your behalf. By completing this, you are also giving permission for authorized benefits to be assigned to provider.*

Emergency Contact _____ Contact's # _____

Authorized Persons with Whom Medical Info May Be Shared _____

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Patient Name: _____ Date: ___/___/___

Medical Physician: _____ Office #: (___)_____ Date of Last Exam: ___/___/___

If you do not have a family doctor, please list a preferred clinic or hospital.

Preferred Pharmacy: _____ Pharmacy #: (___)_____

Are you currently under medical treatment?	_____ Y	_____ N
Have you been hospitalized for any surgical operation/serious illness?	_____ Y	_____ N
If yes, please explain: _____		
Are you taking any medications, including non-prescription medicine?	_____ Y	_____ N
If yes, please list: _____		
Have you ever taken FosaMax, Boniva, Actonel or anything containing bisphosphonates?	_____ Y	_____ N
Have you ever had adverse reaction to medicine or injections? (ex. resistance to numbing)	_____ Y	_____ N
Do you use tobacco?	_____ Y	_____ N
Do you use controlled substances?	_____ Y	_____ N
Do you have a persistent cough or issues clearing your throat? (lasting 3+ weeks)	_____ Y	_____ N
Do you have any allergies? (penicillin, latex, etc.) List here: _____	_____ Y	_____ N
Women Only: Are you pregnant or think you may be pregnant? Are you nursing?	_____ Y	_____ N

Do you have any of the following?

High Blood Pressure	_____ Y	_____ N	Cancer	_____ Y	_____ N
Low Blood Pressure	_____ Y	_____ N	Arthritis	_____ Y	_____ N
Heart Attack	_____ Y	_____ N	Joint Replacement/Implant	_____ Y	_____ N
Rheumatic Fever	_____ Y	_____ N	Hepatitis/Jaundice	_____ Y	_____ N
Swollen Ankles	_____ Y	_____ N	Sexually Transmitted Disease	_____ Y	_____ N
Fainting/Seizures	_____ Y	_____ N	Stomach Troubles/Ulcers	_____ Y	_____ N
Asthma	_____ Y	_____ N	Chest Pains	_____ Y	_____ N
Epilepsy/Convulsions	_____ Y	_____ N	Easily Winded	_____ Y	_____ N
Leukemia	_____ Y	_____ N	Stroke	_____ Y	_____ N
Diabetes	_____ Y	_____ N	Hay Fever/Allergies	_____ Y	_____ N
Kidney Disease	_____ Y	_____ N	Tuberculosis	_____ Y	_____ N
AIDS or HIV Infection	_____ Y	_____ N	Radiation Therapy	_____ Y	_____ N
Thyroid Problems	_____ Y	_____ N	Glaucoma	_____ Y	_____ N
Heart Disease	_____ Y	_____ N	Recent Weight Loss	_____ Y	_____ N
Cardiac Pacemaker	_____ Y	_____ N	Liver Disease	_____ Y	_____ N
Heart Murmur	_____ Y	_____ N	Heart Trouble	_____ Y	_____ N
Angina	_____ Y	_____ N	Respiratory Problems	_____ Y	_____ N
Frequently Tired	_____ Y	_____ N	Mitral Valve Prolapse	_____ Y	_____ N
Anemia	_____ Y	_____ N	Sleep Apnea	_____ Y	_____ N
Emphysema	_____ Y	_____ N	Other: _____	_____ Y	_____ N

Name + Location of Previous Dentist: _____ Date of Last Exam: ___/___/___

Do your gums bleed when brushing/flossing?	___ Y ___ N	Do you bite your lips/cheeks often?	___ Y ___ N
Do you wear dentures? Date of placement: ___/___	___ Y ___ N	Have you ever had a difficult extraction?	___ Y ___ N
Do you have frequent headaches?	___ Y ___ N	Have you had prolonged bleeding after an extraction?	___ Y ___ N
Do you feel pain in any of your teeth?	___ Y ___ N	Have you had orthodontic treatment?	___ Y ___ N
Any sores of lumps in/near your mouth?	___ Y ___ N	Have you ever received oral hygiene instructions?	___ Y ___ N
Have you had any head, neck or jaw injuries?	___ Y ___ N	Do you grind or clench your teeth?	___ Y ___ N
Are your teeth sensitive to hot/cold?	___ Y ___ N		
Are your teeth sensitive to sweet/sour?	___ Y ___ N		
Any difficulty chewing?	___ Y ___ N		

PATIENT HIPAA - CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any other plans for future care or treatment. I understand that this information serves:

- a basis for planning my care and treatment
- a means of communication among the many healthcare professionals who contribute to my care
- a source of information for applying my diagnoses and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that White Smiles reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that White Smiles if not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that White Smiles has already taken in reliance thereon.

I have read and agree to the HIPAA policies above.

Print Name: _____ Date: _____/_____/_____

Sign Name: _____

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OFFICE FINANCIAL & MISSED APPOINTMENT POLICIES

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you have read and understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the office manager.

PATIENT PAYMENT: Payment is due at the time services are rendered. For larger cases, 50% is due at the start of treatment, and the remaining 50% at the last appointment. We accept cash, checks, and all major credit cards. We also offer CARE CREDIT* as an alternative option. Returned checks will have an additional fee of $25.00 added to the amount of the returned check. Please contact the office manager for more information on any of the above payment options.

INSURANCE: As a courtesy to all our patients, we will help file any insurance. The cost of your treatment will be due at time of service and your insurance company will reimburse you the covered portion. It is your responsibility to know what type of coverage you have and to provide us with the correct information. If you have any questions or concerns beyond the initial claim filing, we will be happy to help - just give us a call at (850) 921-8877.

NO SHOW/MISSED APPOINTMENT: We request a notice of 24 hours for the cancellation of appointments. If appropriate notice is not given, a charge of $25 may be assessed to the patient's account. We understand that sometimes last minute cancellations are unavoidable and individual circumstances may be discussed with the office manager.

REFUNDS FOR UNFINISHED TREATMENT: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager.

CREDITS ON AN ACCOUNT: If payment is received that is more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave a credit on the account to be applied towards future treatment.

Our office reserves the right to make changes to these policiies without notice.

Select on of the following options:

1. I would like to pay by cash, check, debit or credit at the time of service _____
2. I would like to apply for an extended payment plan for treatment over $500 through Care Credit* _____

I have read and agree to the policies stated above.

Print Name: _____ Date: _____/_____/_____

Sign Name: _____