

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.

_____	_____	_____
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	

PERSONAL

_____	_____
Employer	Occupation
_____	_____
Work Phone #	

WORK

_____	_____
Insurance Plan	Group Number
_____	_____
Subscriber Name	Subscriber ID
_____	_____
Subscriber SSN	Subscriber DOB

INSURANCE

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

_____	_____
Emergency Contact	Contact's #



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

Do you have frequent headaches? _____ Y _____ N extraction? _____ Y _____ N

Do you feel pain in any of your teeth? _____ Y _____ N Have you had prolonged bleeding after

Any sores of lumps in/near your mouth? _____ Y _____ N an extraction? _____ Y _____ N

Have you had any head, neck or jaw injuries? _____ Y _____ N Have you had orthodontic treatment? _____ Y _____ N

Are your teeth sensitive to hot/cold? _____ Y _____ N Have you ever received oral hygiene

Are your teeth sensitive to sweet/sour? _____ Y _____ N instructions? _____ Y _____ N

Any difficulty chewing? _____ Y _____ N Do you grind or clench your teeth? _____ 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: _____

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 policies 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: _____