ELITE SMILES
DENTAL LTD
119 E MAIN ST – LITTLE CHUTE, WI 54140 – (920)735-9366

MEDICAL HEALTH HISTORY

Patient Name_____ **Date of Birth**___/_____/_____

Please circle the correct response:

Yes No Are being treated by a doctor for something other than routine care? Reason: _____

Physician's Name: _____ Phone Number: _____

Yes No Have you had any surgeries? List: _____

Yes No Are you allergic or sensitive to any medications or substances? List: _____

Yes No Have you taken any bisphosphonates? (Fosamax, Boniva, Zometa, Aredia) For how long? _____

Yes No Do you have artificial joints or heart valves? Date placed & location in body: _____

Please list all prescription medications, supplements, or herbal medicaments you regularly take (or provide a copy of your complete medication / surgery list)**:**

_____

_____

Please check any illnesses, conditions, or diseases that you have had in the past or currently have:

☐	Acid Reflux	☐	Dizziness	☐	Kidney Disease	☐	Seizures
☐	Allergy / Hay Fever	☐	Epilepsy	☐	Low Blood Pressure	☐	Sinus Problems
☐	Alzheimer's	☐	Excessive Bleeding	☐	Malignant Hyperthermia	☐	Stomach Problems
☐	Anemia	☐	Fainting	☐	Mental Disorders	☐	Stroke
☐	Arthritis	☐	Glaucoma	☐	Nervous Disorders	☐	Thyroid Disease
☐	Aritficial Joints	☐	Head Injuries	☐	Osteoporosis	☐	Tuberculosis
☐	Artificial Valve	☐	Heart Disease	☐	Pacemaker	☐	Tumors
☐	Asthma	☐	Heart Murmur	☐	Psychiatric Treatment	☐	Tobacco Use
☐	Blood Disease	☐	Hepatitis	☐	Pregnancy	☐	Use of Other Substances
☐	Cancer	☐	High Blood Pressure	☐	Radiation / Chemotherapy	☐	Ulcers
☐	Cardiac Stents	☐	High Cholesterol	☐	Respriatory Problems	☐	
☐	Diabetes	☐	HIV / AIDS	☐	Rheumatic Fever	☐	

Any other health information not covered that you'd like to share: _____

Patient (or Guardian) Signature: _____ **Date:** _____

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DENTAL HEALTH HISTORY

Please circle the correct response:

Yes No Do you have discomfort with your teeth or gums? Where: _____

Yes No Do your gums bleed or hurt when you brush or floss them? Where: _____

Yes No Does food catch between your teeth? Where: _____

Yes No Do you experience pain from heat, cold or sweets? (Circle any that apply) Where: _____

Personal Dental History (Please check all that apply):

- ☐ Had an unfavorable dental experience
- ☐ Had trouble getting numb for treatment
- ☐ Had/have braces, orthodontic treatment
- ☐ Had any teeth removed
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had your bite adjusted

Bite and Jaw Joint (Please check all that apply):

- ☐ You have problems with your jaw joint (noise or discomfort)
- ☐ You have problems chewing
- ☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
- ☐ Your teeth are becoming crowded or developing spaces
- ☐ You chew ice, bite your nails, use your teeth to hold objects or have any other oral habits
- ☐ You clench your teeth in the daytime or you clench or grind your teeth at night
- ☐ You have headaches more than once a week
- ☐ You wear or have worn a bite appliance

Tooth structure (Please check all that apply):

- ☐ You have had cavities within past 3 years
- ☐ Your mouth is dry or you have difficulty swallowing food
- ☐ You notice holes (i.e. pitting/craters) on the biting surface of your teeth
- ☐ You have grooves or notches on your teeth, chipped teeth, have a toothache or cracked filling
- ☐ You do not like the way that your teeth are shaped or aligned

If any of the checked boxes need further explanation, please describe:

_____

_____

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FINANCIAL POLICY

As a condition of treatment by this office, arrangements for payment must be made in advance. Financial responsibility must be determined before treatment. Our office accepts cash, check, money order, Visa, Master Card, Discover, and Care Credit.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full with cash or with a credit card at the time services are performed.

It is important that patients with dental insurance understand that all dental services not covered by insurance are the responsiblilty of the patient. We will submit dental claims to the insurance companies as a courtesy to our patients. Patient copayments are payable at time of service, unless other financial arrangements have been made. If for any reason your insurance company denies your claim you are fully responsible for payment of services provided.

A 1.5% finance charge will be added monthly to all unpaid balances on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of diagnosis. I further acknowledge that fee estimates are based on visual and x-ray assessment and that the actual condition of the tooth may be different and involve a different fee.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available at your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care.

Please list the person(s) we can discuss your treatment or financials with:

_____

Name & Relationship to You

_____

Name & Relationship to You

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APPOINTMENT CANCELLATION AND NO SHOW POLICY

We understand that unplanned situations can come up and you may need to reschedule an appointment. If that happens we respectfully ask for scheduled appointments to be rescheduled at least 24 hours in advance; 48 hours in advance if the appointment is scheduled for longer than two (2) hours. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

Our doctors and hygienists want to be available for your needs and the needs of all of our patients. When a patient does not show up for a scheduled appointment another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for No Show appointments, and those appointments not rescheduled within 24/48 hour notice.

As of May 1, 2018 there will be a fee of **$25 per hour** of scheduled appointment time assessed if we do not receive a call to reschedule an appointment within 24/48 hours prior to the appointment time. Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. These fees are not covered by insurance and will not be billed to your insurance company.

We understand that special, unavoidable circumstances may cause you to reschedule within 24/48 hours. Fees in this instance may be waived but only with management approval.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Please sign that you have read, understand, and agree to this Financial Policy, Consent for Treatment, Consent for Use and Disclosure of Information Policy, Cancellation and No Show Policy:

Patient Name_____ **Date of Birth**___/_____/_____

Patient (or Guardian) Signature: _____ **Date:** _____

For Office Use Only

We attempted to obtain written acknowledgement our appointment cancellation and no show policy, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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PATIENT REGISTRATION

(Please provide the front desk with a copy of your insurance card)

Patient Name_____ _____ _____
(First Name) (Last Name) (MI)

Preferred Name_____ **Date of Birth**___/_____/_____

Gender: Male / Female **Marital Status:** Single / Married / Widowed / Divorced

Social Security Number_____ **Driver's License Number**_____

Address_____ _____ _____ _____
(Street) (City) (State) (Zip)

Phone Number_____ _____ _____
(Home) (Cell) (Work)

Email Address_____ **Preferred Method of Contact:** Call / Email / Text

How Did You Hear About Our Office?_____

RESPONSIBLE PARTY INFORMATION

(If Someone Other Than Patient Listed Above)

Name_____ _____ _____
(First Name) (Last Name) (MI)

Date of Birth___/_____/_____ **Gender:** Male / Female **Relationship to Patient**_____

Social Security Number_____ **Driver's License Number**_____

Address_____ _____ _____ _____
(Street) (City) (State) (Zip)

Phone Number_____ _____ _____
(Home) (Cell) (Work)