

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: ____ Age: ____

Home address: _____ City: _____ State: ____ Zip: ____

Billing address (if different): _____ City: _____ State: ____ Zip: ____

Home phone: _____ Cell: _____ E-mail: _____

Parent/ Legal Guardian Name: _____ **Relationship to patient:** _____ **Date of birth:** _____

Driver's license #: _____ SS #: _____

Employer/Occupation: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: ____ Zip: ____

Emergency Contact # (other than spouse): _____ Phone #: _____

Referred to us by: _____

* Primary Dental Insurance: _____ Subscribers Name: _____ Date of Birth: _____

Group #: _____ ID# / SSN# _____ Issue date/ Effective date: _____

*Secondary Dental Insurance: _____ Subscriber Name: _____ Date of Birth: _____

Group #: _____ ID# / SSN: _____ Issue date/ Effective date: _____

Name of Medical Doctor: _____ Date of last visit to Medical Doctor: _____

Name of pervious Dentist: _____ Date of dental visit: _____

DENTAL HEALTH HISTORY

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Are you apprehensive about dental treatment?	___	___	Do you take pain medication?	___	___
Have you had problems with previous dental treatment?	___	___	Do you have temporomandibular disorder? (TMD)	___	___
Do you gag easily?	___	___	Are you able to open your mouth as far as you want?	___	___
Do you wear dentures?	___	___	Have you had a blow to the jaw?	___	___
Does food catch between your teeth?	___	___	How often do you brush? _____		
Do you chew on only one side of your mouth per pain?	___	___	How often do you floss ? _____		
Do your gums bleed easily?	___	___			
Do your gums bleed when you floss?	___	___			
Do your gums feel swollen or tender?	___	___			
Are your teeth sensitive?	___	___			
Do you feel twinges of pain when your teeth come in contact with:					
Hot food/liquids	___	___			
Cold food/liquids	___	___			
Sours?	___	___			
Sweet?	___	___			
Are you dissatisfied with the appearance of your teeth?	___	___			
Do you prefer to save your teeth?	___	___			
Do you want complete dental care?	___	___			
Does your jaw make noise so that it bothers you?	___	___			
Do you clench or grind your jaw?	___	___			
Does your jaw get stuck so that you can't open freely?	___	___			
Does it hurt when you chew or open wide to take a bite?	___	___			
Do you have any headaches upon awaking in the morning	___	___			

Patient Name: _____

Medical Health History

Do you have, or have you had, any of the following?

	Yes	No		Yes	No
Heart problems	—	—	Diabetes ?	—	—
Chest pain	—	—	Thirsty or constant dry mouth?	—	—
Shortness of breath	—	—	Tuberculosis?	—	—
Blood Pressure problems	—	—	Family history of diabetes?	—	—
Heart murmur	—	—	Liver trouble ?	—	—
Heart valve Problem	—	—	Other respiratory disease?	—	—
Taking heart medication	—	—	Do you drink alcohol?	—	—
Rheumatic fever	—	—	If so how much _____		
Pacemaker	—	—	Hepatitis, Jaundice?	—	—
Artificial heart valve	—	—	Herpes or other STD?	—	—
Blood problems	—	—	HIV-positive/AIDS?	—	—
Easy bruising	—	—	Do you smoke?	—	—
Frequent nosebleeds	—	—	If so how much? _____		
Abnormal bleeding	—	—	Glaucoma ?	—	—
Blood disease (anemia)	—	—	Do you wear contact lenses?	—	—
Ever require a blood transfusion?	—	—	History or head injury	—	—
Allergy problems	—	—	Epilepsy/neurological disease	—	—
Hay fever	—	—	History of alcohol or drug abuse	—	—
Sinus problems	—	—			
Skin rashes	—	—	Do you have any disease, condition, or problem not listed		
Taking allergy medication	—	—	previously that you feel we should know about ? If so, please		
Asthma	—	—	describe: _____		

Intestinal problems _____
Ulcers _____
Weight gain or loss _____
Special diet _____
Constipation/ Diarrhea _____
Kidney or bladder problems _____

Bone or joint problems _____
Arthritis _____
Back or neck pain _____
Joint replacement _____
(e.g. total hip ,pins ,or implants) _____
Osteoporosis _____

Fainting Spells, Seizures, _____
Stroke(s) _____
Frequent or severe headaches _____
Thyroid problems _____
Persistent cough or swollen glands _____
Premedication required by physician? _____

Cancer / Tumor _____
Are you Allergic, or have you reacted
adversely to any of the following?

Local anesthetic (Novocain) _____
Penicillin or other antibiotics _____
Sulfa drugs _____
Barbiturates, sedatives, or sleeping pills _____
Aspirin, Acetaminophen, or Ibuprofen _____
Codeine, Demerol, or other narcotics _____
Reaction to metals _____
Latex or Rubber dam _____
Other _____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs?	—	—
Anticoagulants (Coumadin)	—	—
High blood pressure medication	—	—
Tranquilizers	—	—
Insulin	—	—
Aspirin	—	—
Digitalis or drugs for heart trouble	—	—
Nitroglycerine	—	—
Cortisone	—	—
Natural remedies	—	—
Nonprescription drug/supplements	—	—
Other _____		

	Yes	No
Women		
Are you taking contraceptives or other hormones?	—	—
Are you pregnant?	—	—
If so, expected delivery date _____		
Are you nursing?	—	—
Have you reached menopause?	—	—
If so, do you have any symptoms? _____		

Patient/Parent Signature: _____
Date _____
Dentist Initial: _____

INSPIRE SMILES DENTAL

Patient Acknowledgement of Receipt of Dental Material Fact Sheet and Notice of Privacy Practices

I _____ acknowledge I have reviewed from Dr. Farhana Rassiwala, DDS. Inc a copy of the Dental Material Facts Sheet and Notice of Privacy Practices.

(Also available at all times online at www.Inspiresmilesdental.com and in the office)

Patient/ Guardian Signature: _____ Date: _____

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a \$35 charge for not showing up for scheduled appointments or rescheduling with out a 24 hour notice.

I have read, understand and agree to the above policy:

Patient/ Guardian Signature: _____ Date: _____

Financial Policy

Thank you for Choosing our office as your dental health care provider. We believe that all patients deserve the very best dental care. We also believe that everyone benefits when specific financial arrangements are agreed upon. All patients must complete our Patient information and insurance forms before seeing the doctor.

- **Full Payment** is due at the time of Service. We accept Cash, Visa, Master card, Discover, and Debit cards. We also offer Care Credit which is an extended payment plan with prior credit approval.
- **Prepay/Deposit Option:** Due to the extensive amount of time our staff and doctor devotes to preparing and reserving appointments for you, we offer a 5% off dental treatment when you pre pay for an appointment and pay in full. Or 10% off when paid in Cash. (Discount will not apply when using Care Credit)
- **Regarding Insurance:** We request that any co-payments, deductibles and any services not covered by your insurance plan be paid at the time of service is provided. The balance is your responsibility whether your insurance company pays or not. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, and age restrictions. Please contact your insurance company for a detail of your benefits. Your Insurance policy is a contract between you and your insurance company. We will do all we can to ensure your estimate is as accurate as possible. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to your account. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with the insurance company.
- **Consent:** I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that the responsibility for payment for dental services provided in this office for myself, or my dependents is mine, due and payable at the time services are rendered.

Patient/Guardian Print: _____

Patient/ Guardian Signature: _____ Date: _____