

**Please bring with you to your first appointment :**

- Photo ID (if over 18)
- Dental Insurance card (if applicable)
- Medical Insurance card



**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  Male  Female Soc.Sec. #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Preferred contact method? (Please Circle) Home Work Cell No Preference  
Employer or School/College(if student): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

**DENTAL INSURANCE INFORMATION:**

**Primary Insurance:**

Insurance Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Subscriber ID/SSN: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Secondary Insurance:**

Insurance Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Subscriber ID/SSN: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**DENTAL HISTORY/ORAL HEALTH:**

Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_  
Date of last dental cleaning: \_\_\_\_\_ How often did you visit before that: \_\_\_\_\_  
What was done at your last visit (circle): XRAYS CLEANING OTHER: \_\_\_\_\_  
How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

**Please indicate if you have had any of the following:**

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Food Collection between teeth	<input type="checkbox"/> Orthodontic Treatment
<input type="checkbox"/> Swollen or Bleeding Gums	<input type="checkbox"/> Grinding or Clenching Teeth	<input type="checkbox"/> Periodontal Treatment
<input type="checkbox"/> Smoking, Vaping, Cigar, Pipe	<input type="checkbox"/> Headaches	<input type="checkbox"/> Earaches or Ear ringing
<input type="checkbox"/> Chewing Tobacco	<input type="checkbox"/> Sensitivity to hot, cold, or pressure	<input type="checkbox"/> Jaw Pain or Tiredness
<input type="checkbox"/> Loose Teeth or Broken Fillings	<input type="checkbox"/> Sores or blisters on lips/mouth	<input type="checkbox"/> Clicking or Popping Jaw

How happy are you with your smile(1-10)? (1= Not at all Happy, 10=I Love my smile!) \_\_\_\_\_  
**Is there anything you would like to change?** \_\_\_\_\_

**MEDICAL CONDITIONS (CHECK ALL THAT APPLY):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD                | <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Fainting or Dizziness       | <input type="checkbox"/> Respiratory Disease     |
| <input type="checkbox"/> Allergies (seasonal)    | <input type="checkbox"/> Artificial Heart Valve /MVP | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Heart Condition _____       | <input type="checkbox"/> Shingles                |
| <input type="checkbox"/> Anxiety/Depression      | <input type="checkbox"/> Hepatitis, Type _____       | <input type="checkbox"/> Sinus Condition         |
| <input type="checkbox"/> Arthritis _____         | <input type="checkbox"/> Herpes, Type _____          | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Artificial Joints _____ | <input type="checkbox"/> High/Low Blood Pressure     | <input type="checkbox"/> Thyroid Condition _____ |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> HPV                         | <input type="checkbox"/> Tinnitus/Vertigo        |
| <input type="checkbox"/> Cancer _____            | <input type="checkbox"/> Kidney Condition            | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Liver Condition             | <input type="checkbox"/> Ulcer                   |
| <input type="checkbox"/> Diabetes Type _____     | <input type="checkbox"/> Pacemaker _____             | <input type="checkbox"/> Other _____             |
| (A1C _____) or Pre-Diabetes                      | <input type="checkbox"/> Psychiatric Care            | _____  |

**WOMEN ONLY:**

- |                      |     |    |  |     |    |
|----------------------|-----|----|--|-----|----|
| A) Are you pregnant? | Yes | No | C) Is there any chance that you may be pregnant? | Yes | No |
| B) Are you nursing?  | Yes | No | D) Are you taking Birth Control?                 | Yes | No |

**MEDICAL HISTORY:**

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Are you under medical treatment now for a current ongoing condition? Yes No

Have you ever been hospitalized for any surgical operation or serious illness? Yes No

Are you allergic to any of the following?

- ASPIRIN       LOCAL ANESTHETICS       CODEINE       PENICILLIN       LATEX  
 OTHER \_\_\_\_\_

**Has your physician ever indicated that you should have Pre-Medication before dental treatment? Yes No**

Have you ever had any complications following dental treatment? Yes No

Are you taking a blood thinner? Yes No

Are you receiving Hormone Replacement Therapy (HRT)? Yes No

Are you taking or have you ever taken bisphosphonates? Yes No

Please list all medications (or attach list):

\_\_\_\_\_  
\_\_\_\_\_

**PHOTOGRAPHIC RELEASE**

Your initials indicate your consent for New Albany Smiles to use, reproduce and publish photographic/computer illustrations of your teeth/mouth for illustrative and educational purposes. It is not mandatory and is done freely and voluntarily.

Patient Initial \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. I certify that I have read and understand the questions, above. The answers provided on this dental and medical history are correct and to the best of my knowledge.

Patient Name (Print) \_\_\_\_\_

Signature (Patient or Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health/dental information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

An official *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information is available upon request. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this dental practice to obtain a current copy of the *Notice of Privacy Practices*.

### HIPAA Health Information Sharing Release:

I, \_\_\_\_\_, hereby authorize the following person(s) the ability to disclose and release of any of my individual personal information pertaining to past, present or future dental health treatment to any of my immediate family members.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

- (a) Request, review and receive any form of dental information, oral or written including clinical notes, x-rays, treatment plans needed, completed dentistry, dental insurance, and finances associated with any or all of my dental treatment.
- (b) Can execute on my behalf any releases or documents that may be required in order to obtain information including, but not limited to: Valid Authorization to share information under the Ohio Confidentiality of Dental Information Act and Insurance Portability and Accountability Act.

This authorization is effective immediately and has no written expiration date. I understand that I have the right to revoke the authority in writing at any time and deliver it to my dental care provider.

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature (Patient or Parent/Guardian)

\_\_\_\_\_  
Date



## FINANCIAL POLICY

### Payment Agreement:

I agree that I am responsible for all services rendered and that payment is due at the time treatment is rendered and that all insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service. We are happy to provide you with an estimate in advance (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage).

I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered.

### Financial Agreement:

I understand that the Practice may charge: 1) a fee for each appointment that is missed/cancelled without at least 24 hours advance notice. 2) a finance charge (interest at a rate of 1.5%) if payment on my account is not received by the due date; and 3) Returned checks will be subject to a fee of \$35.00. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees, collection charges, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

Initial: \_\_\_\_\_ **Patient co-pays are due the same day service is rendered. Statement balances are due at the time of receipt.**

Initial: \_\_\_\_\_ **We respectfully ask our patients to arrive on time and keep all reserved appointments with us. We will try to remind you by telephone, text and/or e-mail prior to your scheduled time, but please do not rely upon this courtesy. If you are unable, for any reason, to keep your previously reserved time with us, we require a minimum of 2 business days to avoid a possible lost time charge of \$85.00 or 1/3 the value of the lost appointment time to your account.**

We are committed to providing you with the best and most comfortable care in a positive environment, while helping you understand your responsibilities to our practice. We do understand that emergencies can occur, and request that you contact our office to avoid any misunderstandings in regard to your account.

I have read, initialized at the appropriate areas, and agree to the terms listed above.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature (Patient or Parent/Guardian)

\_\_\_\_\_  
Date