Welcome to
Tyler L. Smith Family Dentistry

Today's Date:______________

Patient Information

Last:_______________________First:____________________Middle Initial:____Preferred:_____________

Address:_____________________________________ City:________________State:______ Zip:__________

Home #:______________________________________Cell #:____

Email:_______________________________________Work #:____

Sex:______Birth Date:_______________Social Security #:___________________Marital Status: _________

Emergency Contact:___________________________ Emergency Contact #:___________________________

How did you hear about our practice?____

Whom may we thank for referring you?____

Responsible Party (if patient is under the age of 19)

Last:_______________________First:______________________Middle Initial:_____Preferred:____________

Relation to Patient:_______________*Please answer the questions below, unless responsible party is an existing patient**

Address:_____________________________________ City:________________State:______ Zip:__________

Sex:______Birth Date:__________________Social Security #:_________________Marital Status:_________

Phone #:____________________________________Email:____

Primary Insurance Information

Last Name of Insured:___________________________First Name of Insured:__________________________

Birth Date:________________Social Security #:__________________Relation to Patient:________________

Employer of Insured: ____

Insurance Company:_____________________________Insurance Company #:________________________

Policy # (Plan, Group, or Local #):__________________Identification #:_______________________________

Secondary Insurance Information

Last Name of Insured:___________________________First Name of Insured:__________________________

Birth Date:________________Social Security #:__________________Relation to Patient:________________

Employer of Insured: ____

Insurance Company:_____________________________Insurance Company #:________________________

Policy # (Plan, Group, or Local #):__________________Identification #:_______________________________

Insurance Assignment

I hereby instruct and direct my insurance companies listed above to pay Tyler Smith Family Dentistry directly for the dental benefits allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A scanned copy of this Assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or other healthcare provider. I hereby appoint Tyler Smith Family Dentistry to act on my behalf as my representative to appeal any decisions made by the insurance company. I request and authorize TSFD to initiate a complaint to the Insurance Commissioner, for any reason, on my behalf.

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Signature of Responsible Party

Dental Information

Time since last dental cleaning________________________Time since last dental x-rays_________________________

How often do you brush your teeth?_____________________How often do you floss?____________________________

Do your gums bleed when you brush or floss? Y N

Have you had any problems associated with previous dental treatment? Y N

Have you ever had an injury to your jaw or mouth? Y N

Restorative Dentistry

Do you have active dental problems? Y N

If yes, please describe: ____

If you have any missing teeth, would you like to discuss options for replacement? Y N

Periodontal Condition

Have you had periodontal (gum) treatments or "deep cleanings"? Y N

If yes, how long ago? ____

Do you have any loose teeth? Y N

Do you experience dry mouth? Y N

Clenching and Grinding

Are you aware of clenching or grinding your teeth? Y N

If yes, during the day? Y N

While you sleep? Y N

Do you experience headaches or sore jaw muscles upon awakening in the morning? Y N

Do you experience constant discomfort when opening or closing your jaw? Y N

Sleep Apnea

Have you ever been diagnosed with sleep apnea? Y N

If yes, what type of treatment do you utilize?___________________________________

Have you ever tried, but subsequently given up on, a CPAP machine? Y N

Orthodontics

Have you ever had orthodontic (braces) treatment? Y N

Whitening

Have you ever whitened your teeth? Y N

If yes, were you pleased with the result? Y N

Would you like to learn more about whitening options? Y N

Medical Information

***Do you require antibiotics before dental treatment? Y N

Are you currently under the care of a physician (primary care or specialist)? Y N

Physician Name:____________________________ Location:___________________________

Has there been any change in your general health in the past year? Y N

If yes, what condition is being treated?____

Have you had a serious illness, operation, or been hospitalized in the past 2 years? Y N

If yes, what was the illness or problem?_______________________________________

Joint Replacement

Have you had an orthopedic total joint (i.e. hip, knee, elbow, etc.) replacement? Y N

Date of the surgery: ____

Have you had any complications since the joint replacement? Y N

Bisphosphonates

Are you taking or scheduled to begin taking either oral or intravenous bisphosphonate drugs (i.e. Fosamax, Actonel, Boniva, Reclast, etc.) for treatment of osteoporosis, Paget's disease, multiple myeloma, metastatic cancer, or any other condition or disease? Y N

Date treatment began/is scheduled to begin:___________________________________

Tobacco

Do you use tobacco products? Y N

If yes, in what form(s)?____

Women Only

Are you pregnant? Y N

If yes, number of weeks:____

Are you taking birth control? Y N

Allergies

Are you allergic or ever had an adverse reaction to:

Latex (i.e. rubber)	Y	N	Aspirin	Y	N
Penicillin	Y	N	Ibuprofen (e.g. Advil)	Y	N
Codeine, Hydrocodone, or Other Narcotics	Y	N	Acetaminophen (e.g. Tylenol)	Y	N
Sedatives, Barbiturates, or Sleeping Pills	Y	N	Sulfa drugs	Y	N
Local/Dental Anesthetics (e.g. Novocaine)	Y	N	Other antibiotics not listed	Y	N
Other allergies? If yes, please list.	Y	N	Metals (earrings, jewelry, etc.)	Y	N

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Prescriptions

Are you taking or have you recently taken any prescription or over the counter medications? Y N

If yes, please list all medications:____

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Medical Information Continued

Please mark your response to indicate if you have (past or present) any of the following diseases or problems.

Condition	Y	N	Condition	Y	N
Artificial (prosthetic) heart valve	Y	N	Kidney Disease	Y	N
Previous infective endocarditis	Y	N	Hepatitis A, B, or C	Y	N
Damaged heart valves	Y	N	Liver problems	Y	N
Congenital Heart Disease (CHD)	Y	N	Stomach ulcers	Y	N
Unrepaired/cyanotic CHD	Y	N	Gastric reflux/persistent heartburn	Y	N
Repaired completely in last 6 mo.	Y	N	Eating disorder	Y	N
Repaired CHD with residual defects	Y	N	Diabetes	Y	N
High blood pressure	Y	N	If yes, is it well controlled?	Y	N
Low blood pressure	Y	N	Osteoporosis	Y	N
Cardiovascular disease	Y	N	Anemia or other blood disorder	Y	N
Congestive heart failure	Y	N	Abnormal bleeding or hemophilia	Y	N
Heart attack	Y	N	Blood thinners (e.g. Coumadin, Plavix, Pradaxa)	Y	N
Heart murmur	Y	N	AIDS, HIV, anti-HIV, ARC	Y	N
Heart surgery	Y	N	Cancer/chemo/radiation treatment	Y	N
Angina (chest pain)	Y	N	Frequent dizziness or fainting	Y	N
Rheumatic heart disease/fever	Y	N	Lupus	Y	N
Mitral valve prolapse	Y	N	Excessive bleeding upon injury	Y	N
Stroke	Y	N	Asthma, bronchitis, or emphysema	Y	N
Pacemaker	Y	N	Sinus infection	Y	N
Seizures, epilepsy, convulsions	Y	N	Tuberculosis	Y	N
Other neurological disorder (list below)	Y	N	Mental health disorder	Y	N

Do you have any disease, condition, or problem that is not listed above? Y N

Please explain: ____

____

____

Note: Please inform Dr. Smith or Dr. Hascall or staff of any changes in health status at future visits.

I certify that I have read and understand the above and that the information given on this form is accurate, I understand that Dr. Smith and Dr. Hascall will rely on this information to treat me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his staff responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this form. If I ever have any change in my health, I will inform Dr. Smith or Dr. Hascall or their staff at my next appointment without fail.

______________________________ ______________________

Signature of Patient/Parent/Legal Guardian Date

Financial Information

Methods of Payment

Your portion is due on the date service is rendered.

1. Cash, check, or credit card (MasterCard, Visa, or Discover)
2. Dental Insurance (described below)
3. Application available for third party financing

Dental Insurances

1. Our office will assist you in obtaining the maximum benefits specified in your contract. **However, your insurance is between you, your employer, and the insurance company**.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits. Our computer system will estimate your portion based on the information you have provided us. **We ask that your estimated co-payment and deductible be paid at the time of service.**
3. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.**

Related Information

1. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month or 18% annual. Returned checks will be assessed additional fees and will be turned over to the county attorney's office for collection if not paid in a timely manner.
2. In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for the collection of your bill.
3. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. **24 hour notice** to change an appointment is required to avoid a missed appointment charge.
4. By signing this document, you acknowledge that you have read and understand the above information and that you are responsible (regardless of insurance) for any charges incurred from services rendered.

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 information. I understand that this information can and will be used to:

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

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound by such restrictions.

____ ____________________
Signature of Patient/Parent/Legal Guardian Date

Privacy Authorization

Staying within the reasonable guidelines of HIPAA, I give permission to Smith Family Dentistry to discuss my dental care, related issues, and accounts with the following persons, in addition to myself. If none, please leave blank.

____ ____________________
Name Relationship

____ ____________________
Name Relationship

Minor/Child Consent

I, being the parent or guardian of _________________________ do hereby request and authorize the dental
Name of minor(s)
staff to perform necessary dental services for my child, including, but not limited to, X-rays and the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the time that treatment is rendered.

____ ____________________
Signature of Patient/Parent/Legal Guardian Date