PATIENT INFORMATION

First Name:_____________________ MI:____ Last:__________________________
Preferred:________________ Birth Date:______________________ Age:________
SS#:___________________________ Sex: M F
Cell Phone: ___________________
Work Phone: __________________EXT______
Home Phone: __________________
Which is the best Number/Time to reach you? _______________________
Text or Email reminders? ____________

Address:____City:___________________
State:_____ Zip:__________ Email:____ □
Married/Partnered □ Widowed □ Single □ Minor
Emergency Contact: __________________________________
Relationship:____________Phone:_________________

Who may we thank for referring you? (Choose one)
Google Friend/Family Referral TV Social Media Other Provider

DENTAL INSURANCE INFORMATION
PRIMARY Insurance Information:
Insurance Company______________________________ Customer Service Phone
Number__________________ Employer_______________________________________ Group
Name_________________ Group Number______ Subscriber _________________________
DOB________ Subscriber/Member ID/SSN_______________________ Relationship to Patient
____

SECONDARY Insurance Information: (if applicable)
Insurance Company______________________________ Customer Service Phone
Number__________________ Employer_______________________________________ Group
Name________________ Group Number_______ Subscriber_________________________
DOB________ Subscriber/Member ID/SSN_______________________ Relationship to Patient
____

DENTAL HISTORY

Date of last dental visit: ________________________
Name of your previous dentist: _________________
Reason for your visit today: _____________________
Have you ever had an oral cancer screening? Y or N
How often do you brush? ________________________
How often do you floss? ________________________
Have you/family member ever been treated for periodontal disease? Y or N
Have you ever had complications from an extraction? Y or N
Have you ever had popping/clicking near your ear when you chew? Y or N
Are you prone to frequent headaches? Y or N
Do you grind/clench your teeth? Y or N
Do you have any of the following?
□ Sores □ Blisters □ Loose/Broken fillings □ Dry Mouth □ Food Collection □ Bleeding Gums
□ Mouth Breathing □ Nail Biting □ Chew on one side □ Swollen/Tender: Gums, Lips, Cheeks

Have you ever had Orthodontic treatment? Y or N
Do you snore? Y or N
Do you have problems with bad breath? Y or N
Have you ever had an allergic reaction to: □ crown □ metal filling □ dental appliance
Have you ever used a Power Toothbrush? Y or N
Waterpik? Y or N
Are your teeth sensitive to any of the following:
□ Hot □ Pressure □ Cold □ Sweets

Please indicate how important your dental health is to you (10 being most important)
1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be?
□ Whiter □ Close space □ Replace dark fillings with tooth colored restorations □ Repair Chipped teeth □ Replace Missing teeth □ Replace old crowns that don't match

PATIENT HEALTH HISTORY

	Y N		Y N		Y N
AIDS/HIV	□ □	Emphysema	□ □	Jaw Pain	□ □
Allergies__________	□ □	Epilepsy/Seizures	□ □	Joint Replacement	□ □
Anemia	□ □	Excessive Bleeding	□ □	Kidney Disease	□ □
Arthritis	□ □	Fainting/Dizziness	□ □	Liver Disease	□ □
Artificial Valves	□ □	Glaucoma	□ □	Low Blood Pressure	□ □
Asthma	□ □	Headaches	□ □	Mitral Valve Prolapse	□ □
Blood Disease	□ □	Hearing Impaired	□ □	Neck/Back Problems	□ □
Cancer ___________	□ □	Heart lesions	□ □	Nervous Problems	□ □
Chemical Dependency	□ □	Heart Murmur	□ □	Pacemaker	□ □
Chemotherapy	□ □	Heart Problems	□ □	Psychiatric Care	□ □
Circulatory Problems	□ □	Hepatitis __________	□ □	Radiation Treatment	□ □
Cortisone Treatments	□ □	Herpes	□ □	Respiratory Problems	□ □
Cough, persistent	□ □	High Blood Pressure	□ □	Rheumatic Fever	□ □
Diabetes	□ □	Jaundice	□ □	Scarlet Fever	□ □
Shortness of Breath	□ □	Rash	□ □	Sinus Problems	□ □
Thyroid Disease	□ □	Swollen Neck glands	□ □	Swollen Feet/ankles	□ □
Tonsillitis	□ □	Tumor/Growths	□ □	Venereal Disease	□ □
Tuberculosis	□ □	Ulcers	□ □	Weight change, un-explained	□ □

MEDICAL QUESTIONS:

List any Medications you are taking - include nonprescription drugs:____
____
____
____

Are you allergic to □ Penicillin □ Local Anesthesia □ Latex □ Sulfa □ Barbiturates □ Iodine □ Aspirin □ Codeine □ Other____________________________
Are you in good health? Y or N
Date of last medical exam ________________________________
Have you ever been hospitalized? Y N
if yes, please explain______________________________________
Pharmacy____
Do you have any additional disease/problem that we should know about?
____
____

Have you had a transplant operation that has depressed your immune system?	Y or N
Have you had an allergic reaction to bananas?	Y or N
Do you smoke or use tobacco?	Y or N
Have you had Heart surgery?	Y or N
Are you currently under the care of an MD?	Y or N
Are you/have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc)	Y or N
Women: Are you Pregnant or Nursing?	Y or N
Taking birth control?	Y or N

Financial and Cancellation Agreement:

Thank you for choosing The Smile Line Studio as your new dental home! Please take a moment to read the following, sign and date the bottom of this form.

We are an out-of-network provider, we kindly ask for payment for treatment to be remitted on or before your scheduled appointment. We will not initiate treatment or complete treatment until full payment is received. We will file most primary insurances at no cost to you as a courtesy. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved, as this time could be given to another patient in need. If a 24- hour notice is not given, a cancellation fee of a minimum $50 will apply

There will be a minimum fee of $50 for any checks returned as Non-Sufficient Funds (NSF).

Patient balances that go unpaid for 60 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost of a minimum of $50. Further, in the event any unpaid account balance is referred to an attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith. I understand that and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf. I understand that I will be liable for the collection cost of a minimum of $50. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

Patient name: ____________________
Signature of Patient or Guardian: __________________
Date: __________________

Photo Consent Form:

I give permission to The Smile Line Studio and its representatives to use any photographs taken of me during my dental treatment for the following purposes:

1. Marketing Purposes: These photographs may be used in promotional materials, including but not limited to:
- Printed materials such as brochures, flyers, and posters.
- Digital media such as the clinic's website, social media platforms, and online advertisements.

2.Educational Purposes: These photographs may be used for educational purposes, including:
- Presentations to other dental professionals.
- Educational seminars or courses.
- Scientific publications or journals.

Confidentiality and Use:
- The Smile Line Studio assures that all photographs will be used in a professional manner and will not disclose any patient information without explicit consent.
- The photographs may be stored securely by The Smile Line Studio for future use as described above.

Revocation of Consent:
- I understand that I may revoke this consent at any time by providing written notice to The Smile Line Studio.

Financial Compensation:
- I acknowledge that I will not receive financial compensation or royalties for the use of these photographs.

Consent: I have read and understood the information provided above regarding the use of photographs taken during my treatment at The Smile Line Studio. I hereby consent to the use of these photographs for marketing and educational purposes as described.

Patient name: ____________________
Signature of Patient or Guardian: __________________
Date: __________________

Consent to Treat Form:

I give permission for The Smile Line Studio to give me medical treatment. I allow The Smile Line Studio to file for insurance benefits to utilize my insurance benefit but I understand that payment for my treatment is required day of my appointment in order for them to file to my insurance.

I understand that:

- The Smile Line Studio will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient name: ____________________
Signature of Patient or Guardian: __________________
Date: __________________

Communication Consent:

The Smile Line Studio reserves the right to send text communications regarding practice updates, marketing promotions and feedback requests. I understand that by providing a cell phone number, I agree to receive texts from The Smile Line Studio. At any point, you can optout. Message and data rates may apply. Thank you for being a valued patient of The Smile Line Studio.

Patient name: ____________________
Signature of Patient or Guardian: __________________
Date: __________________