

# The Smile Spot

## New Patient Form

Patient Information:

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male/Female

Mailing Address: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Parent / Guardian (If Applicable): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name & Phone Number: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How did you hear about our dental office? Friend / Relative Employee Sign/Flyer/Mailer Other: \_\_\_\_\_

Are you nervous about dental treatment? YES / NO Do your gums bleed/feel irritated? YES / NO

Are your teeth sensitive to any of the following? Hot Cold Sweets Pressure

Are you happy with the overall appearance of your teeth? YES / NO

If no, please explain why: \_\_\_\_\_

Are you currently seeing a medical physician? YES / NO

If yes, please explain why/the condition being treated: \_\_\_\_\_

Are you taking any medication? YES / NO

If yes, please list the medication, dosage and reason for taking: \_\_\_\_\_

Do you smoke? YES, \_\_\_\_\_ / day NO Do you use recreational drugs? YES / NO

Are you pregnant? YES, \_\_\_\_\_ months NO N/A If yes, did you bring a clearance? YES / NO

Please circle any/all of the following conditions you have or have had in your lifetime:

ADD/ADHD	Glaucoma	Rheumatism	Tuberculosis	Cancer / Chemo
Asthma	AIDS/HIV	Seizure/Epilepsy	Anemia / Hemophilia	Scarlet Fever
Autism	Pacemaker	Thyroid Disease	Kidney Problem	Emphysema
Hepatitis	Diabetes	Osteoporosis	Heart Disease / Attack / Murmur	
High Blood Pressure	Other: _____			

Please circle any of the following you are allergic to:

Aspirin / Tylenol / Ibuprofen	Barbiturates / Sedatives / Sleeping Pills	Latex	
Penicillin / Antibiotics	Codeine / Narcotics	Sulfa Drugs	Anesthetic / Lidocaine
Other: _____			

I have answered the above information to the best of my knowledge. If there are any changes to my / the patient's health or medication, I will inform the office as soon as possible.

\_\_\_\_\_  
Patient / Parent / Guardian Signature

\_\_\_\_\_  
Today's Date

### FOR OFFICE USE ONLY

\_\_\_\_\_  
Dr

\_\_\_\_\_  
Weight

\_\_\_\_\_  
Date

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**The Smile Spot**  
**New Patient Insurance / Payment Responsibility**

Insurance Information:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Phone Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Plan ID#/Policy Holder's SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Phone Number (if different from patient): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Is there a secondary insurance? YES / NO

Secondary Insurance Company: \_\_\_\_\_

Secondary Insurance Co. Phone Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Plan ID#/Policy Holder's SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Address if different from patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

By signing below, I understand that any prices given to me by The Smile Spot are an estimate based on information given from my insurance company, any amount not paid by my insurance company / companies will become my responsibility. It is my responsibility to know and understand my insurance coverage and limitations, and to ensure I am covered on the day of my dental visit. I understand that if I have a secondary insurance, there is no guarantee they will pay the full estimated amount. I have answered all the information to the best of my knowledge and ability. If there are any changes to my insurance, health or medication, I will alert the dental office as soon as possible.

\_\_\_\_\_  
Patient / Parent / Guardian Signature

\_\_\_\_\_  
Date

**HIPAA ACKNOWLEDGEMENT**  
**CONSENT OF DISCLOSURE**

(For the Usage and or Disclosure of Protected Health Information)

**THE SMILE SPOT PRIVACY AND CONSENT**

1. I authorize the doctor/staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my/the patient's dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor/staff, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor can choose and employ such assistance as deemed fit to provide recommended treatment.
4. I have answered all the above questions to the best of my knowledge. If there have been any changes to my insurance, health or medication, I have and/or will inform my dentist during my next appointment.

I, the undersigned, hereby authorizes that I have read, understand and agree to the above conditions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give consent to **THE SMILE SPOT** to use and disclose my protected health information for treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed and delivered to the address below. You may deliver this in person or by mail but it will only be effective when we receive it.

You have the right to request restriction on the usage and disclosure of your health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, however if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure for your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by requesting it from the front desk staff.

I have had an opportunity to review the Notice of Privacy Practices.

Print Name of Patient \_\_\_\_\_

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

Parent or Guardian of Patient (if applicable)

Print your Name \_\_\_\_\_

