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**

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 be 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 _____

Relationship ____