

Smiles By Design

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: _____ E-Mail Address: _____ [] Male [] Female
Name: _____ I preferred to be called: _____
Birthday: ___/___/___ Age: _____ SS#: _____
Home Address: _____
[] Single [] Married [] Divorced [] Widowed [] Separated

Home (____) _____ Pager/Cell(____) _____ Wk#:(____) _____ Ext: _____

Employer: _____
Employer's Address: _____
How long there? _____ Occupation: _____
Where & when are the best times to reach you? _____
Whom may we thank for referring you? _____

Other family members seen by us _____
Previous/Present Dentist: _____ Last Visit date: _____

Spouse Information

His/Her Name _____ Employer: _____
Wk# : _____ Ext: _____ SS# _____ Birthdate: ___ / ___ / ___

Insurance (Primary Insurance)

Dental Coverage [] yes [] no
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____ - _____ Group # (Plan, Local or Policy #) _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ___ / ___ / ___ Insured's ID #: _____
Insured's Employer: _____ Employer Address: _____

Secondary Insurance

Dental coverage [] yes [] no
Insurance Co. Name: _____ Ins. Co. Address: _____
Insurance Co. Phone #: (____) _____ - _____ Group (Plan, Local or Policy #) _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ___ / ___ / ___ Insured's ID #: _____
Insured's Employer: _____ Employer's Address: _____

Neighbor or Relative not living with you

His/Her Name : _____ Relation: _____
Wk #: _____ HM# :(____) _____ - _____
Address: _____

Medical History

Do you have a personal physician? [] yes [] no
Physician's Name: _____ Phone #: _____ Last visit: _____
Are you currently under the care of a physician? [] yes [] no
Please explain: _____

You current physical health is? good fair poor

Do you smoke?: yes no

Have you had any metal rods or pins placed? yes no

Are you taking any prescription or over the counter medications? yes no

Please list each one: _____

Do you require pre-medication prior to dental visit?: yes no

If yes for which condition? _____

For Women: Are you using a prescribed method of birth control? yes no

Are you pregnant? yes no Week #: _____

Are you nursing? yes no

Have you ever had any of the following diseases or medical problems

(Please circle one)

Y	N	Abnormal/bleeding		Y	N	Herpes/fever blisters
Y	N	Alcohol/drug abuse		Y	N	High blood pressure
Y	N	Anemia		Y	N	HIV + /Aids
Y	N	Arthritis		Y	N	Hospitalized for any reason
Y	N	Artificial bones/valves/joints		Y	N	Kidney problems
Y	N	Asthma		Y	N	Liver disease
Y	N	Blood transfusion		Y	N	Low blood pressure
Y	N	Cancer/chemotherapy		Y	N	Lupus
Y	N	Colitis		Y	N	Pacemaker
Y	N	Diabetes		Y	N	Psychiatric problems
Y	N	Difficulty breathing		Y	N	Radiation treatment
Y	N	Emphysema		Y	N	Rheumatic/scarlet fever
Y	N	Epilepsy		Y	N	Seizures
Y	N	Fainting spells		Y	N	Shingles
Y	N	Frequent headaches		Y	N	Sickle cell disease/traits
Y	N	Glaucoma		Y	N	Sinus problems
Y	N	Hay fever		Y	N	Stroke
Y	N	Heart attack		Y	N	Thyroid problems
Y	N	Heart murmur		Y	N	Tuberculosis (TB)
Y	N	Heart surgery		Y	N	Ulcers
Y	N	Hemophilia		Y	N	Venereal disease
Y	N	Hepatitis				

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Yes No Aspirin Yes No Erythromycin Yes No Tetracycline
 Yes No Codeine Yes No Latex Yes No Other
 Yes No Dental Anesthetics Yes No Penicillin

Please list any other drugs/materials that you are allergic to: _____

Are any of your teeth sensitive to:			Have you ever had:		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral surgery?	Yes	No
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No	A bite plate or mouth guard?	Yes	No
Do your gums bleed or hurt?	Yes	No	Clicking or popping of the jaw?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No	Difficulty in opening or closing the mouth?	Yes	No
Does food tend to become caught in between your teeth? Where _____?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No	Headaches, neckache or shoulder aches?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No
Mouth breath while awake or asleep?	Yes	No	Would you like to keep your teeth all your life	Yes	No
Have tired jaws, especially in the morning?	Yes	No	Smoke chew tobacco?	Yes	No

What is the reason for your visit today? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Payment is due in full at the time of treatment

I understand that I am responsible for payment of services and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Oceanside Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information including the diagnosis and records of treatment of examination rendered, to my insurance company.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____

FINANCIAL POLICY FOR OCEANSIDE FAMILY DENTAL, LLP

We want our patients to be fully informed of our financial policy. We are committed to providing you with the best possible care. If you have dental insurance, we are determined to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our financial policy.

We make every effort to schedule your appointment at your preferred times. Because of the considerable loss of revenue to the practice, a charge may be levied for broken appointments, or appointments cancelled without twenty four hours advance notice.

If you have dental insurance, you must bring a completed dental claim form or proof of insurance and we will assist you by submitting your insurance claims. (Please understand that New York State Law stipulates that if you have two dental policies, both must be submitted; please inform our staff of all your insurance. However, you must realize:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the date service is rendered.
3. Our fees are considered to fall within the acceptable range (U.C.R.) for our area, and some insurance companies will determine their own U.C.R. and maximum fees.
4. Not all services are covered in all contracts. Some insurance companies exclude certain services from their plan.
5. Please understand that our recommendations follow standards of care not what your insurance will or will not cover.
6. Please inform our staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.
7. Please understand that all laser procedures need to be paid in full at time of visit.

We must emphasize that as dental care providers, our relationship is with **you and not with your insurance company**. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date service is rendered.

I HAVE READ THE POLICIES DESCRIBED IN THIS FORM. I AGREE TO FOLLOW ALL TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILITY TO THE PRACTICE.

_____ I will elect to pay in full at time of visit

_____ I elect to pay all estimated co payments and deductibles at time of visit. I understand it is my responsibility to bring cash, check or major credit card to every appointment. (If you choose this option, credit card must be left on file and outstanding balances will be reconciled when insurance payments are received.)

Credit card: Visa MC AMEX DISCOVER # _____
EXP _____

CCV Code (security code) _____

Signature of patient / responsible party _____ Date: _____