smilee DENTAL

PATIENT REGISTRATION

PATIENT INFORMATION

Date:	Patient Name: Last Name First Name Initial		
Birthdate:	Age:	Soc. Sec. #:	Sex: ☐ Male ☐ Female
Street Address:			
City:	State:	Zip:	
Email Address:	Driver's License #:		
Home phone:	Work phone:	Cell phone:	
Check one: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor ☐ Partnered for _____ years			
Occupation:	Employer/School:		
Employer/School Address:	Employer/School Phone:		

SPOUSE INFORMATION

Spouse Name: Last Name First Name Initial			
Birthdate:	Age:	Soc. Sec. #:	Sex: ☐ Male ☐ Female
Employer:	Employer Phone:		

MINOR INFORMATION

Parent/Guardian Name: Last Name First Name Initial		
Address (if different from patient's):		
Home phone:	Work phone:	Cell phone:
Birthdate:	Age:	Soc. Sec. #:	Sex: ☐ Male ☐ Female
School:	Employer:	Phone:

DENTAL INSURANCE

Insurance Company Name:	Phone #:	
Address:		
Subscriber Name:	Birthdate:	
Subscriber #:	Group #:	Group Name:
Whom may we thank for referring you?		

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MEDICAL HISTORY

Date:	Patient Name:	Birth Date:

HEALTH HISTORY

Physician's Name:	Phone:	Date of Last Visit:

Please check (✓) if you have or have had problems with any of the following:			
☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	Heart Problems
☐ Yes ☐ No	AIDS/HIV	☐ Yes ☐ No	Hepatitis Type _____
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Arthritis, Rheumatism	☐ Yes ☐ No	Jaw Pain
☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Kidney Disease
☐ Yes ☐ No	Artificial Joints	☐ Yes ☐ No	Liver Disease
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Low Blood Pressure
☐ Yes ☐ No	Bleeding Abnormality	☐ Yes ☐ No	Mitral Valve Prolapse
☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No	Pacemaker
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Psychiatric Care
☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No	Radiation Treatment
☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Respiratory Disease
☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No	Rheumatic Fever
☐ Yes ☐ No	Cough, persistent or bloody	☐ Yes ☐ No	Shortness of Breath
☐ Yes ☐ No	Diabetes A1C Level _____	☐ Yes ☐ No	Sinus Trouble
☐ Yes ☐ No	Depression	☐ Yes ☐ No	Skin Rash
☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Thyroid Problems
☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Tonsillitis
☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Ulcer
☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Weight loss, unexplained
Any other medical problems not listed above?		☐ Yes ☐ No	Oral Cancer
☐ Yes ☐ No	Women: Are you pregnant?	☐ Yes ☐ No	Women: Taking birth control?
☐ Yes ☐ No	Surgeries?	If so, name of medication:	
☐ Yes ☐ No	Do you require an antibiotic pre-medication for your dental appointments?		
☐ Yes ☐ No	Have you had any changes in your health during the last 12 months?		

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

ALLERGIES

List any allergies:

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DENTAL HISTORY

Date:	Patient Name:	Birth Date:

Previous Dentist:	
Address:	Phone:
Date of Last Appointment:	Date of Last X-Ray:
Why did you leave your previous dentist?	

Please check (✓) if you have or have had problems with any of the following:			
☐ Yes ☐ No	Bad breath	☐ Yes ☐ No	Gums swollen or tender
☐ Yes ☐ No	Bleeding gums	☐ Yes ☐ No	Jaw pain or tiredness
☐ Yes ☐ No	Blisters on the lips or mouth	☐ Yes ☐ No	Lip or cheek biting
☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No	Loose teeth or broken fillings
☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No	Mouth breathing
☐ Yes ☐ No	Cigarette, pipe, cigar smoking	☐ Yes ☐ No	Orthodontic treatment
☐ Yes ☐ No	Clicking or popping jaw	☐ Yes ☐ No	Pain around ear
☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No	Periodontal treatment
☐ Yes ☐ No	Fingernail biting	☐ Yes ☐ No	Sensitivity to cold, heat, or sweets
☐ Yes ☐ No	Food collection between teeth	☐ Yes ☐ No	Sensitivity when biting
☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Sores or growths in mouth
How often do you brush?		How often do you floss?	
How often do you have your teeth cleaned?			

Questions relating to the teeth, gums and soft tissue:			
Do you eat snacks or drink beverages containing sugar between meals 4 or more times per day?			☐ Yes ☐ No
Do you drink flouridated water or use fluoride supplements?			☐ Yes ☐ No
Do you use non-prescription fluoride products (fluoride toothpaste or rinses)?			☐ Yes ☐ No
Do you have any special health care needs that might interfere with good home care?			☐ Yes ☐ No
Have you used xylitol (sugar substitute in mints & gums) products 4x daily for the last 6 months?			☐ Yes ☐ No
Have you used calcium & phosphate toothpaste during the last 6 months?			☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No	Do you consume alcohol?	☐ Yes ☐ No
If you answered yes to the previous question, please answer the following:			
What is the average number of drinks consumed in the past year?			
☐ Less than 1 drink per day ☐ 1 drink per day ☐ 2 drinks per day ☐ 3 or more drinks per day			
Have you ever smoked cigarettes or cigars?		☐ Yes ☐ No	
If you answered yes to the previous question, please answer the following:			
How many cigarettes or cigars are/were you smoking per day?		☐ 0-9 per day	☐ 10+ per day
How many years did you or have you smoked?		☐ 0-9 years	☐ 10+ years
If you quit, how many years ago did you quit smoking?		☐ 0-9 years ago	☐ 10+ years ago
Have you ever used smokeless tobacco?			☐ Yes ☐ No
If you answered yes to the previous question, please answer the following:			
How often is or was smokeless tobacco used?		☐ Use occasionally	☐ Use daily
How many years did you or have you used smokeless tobacco?		☐ 0-9 years	☐ 10+ years
If you quit, how many years ago did you quit using smokeless tobacco?		☐ 0-9 years ago	☐ 10+ years ago

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18 Morris Ave. Ste 3B
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(973)218-6027

Financial Agreement

Payments for services is due at the time of your appointment. Payment may be made by cash, check, or credit card.

After the first visit, we may accept your insurance. If so, you will be responsible for payment of deductible and the amount of your co-insurance due at time of treatment.

Insurance coverage is designed to pay only a portion of the costs of your treatment. Very few insurance plans pay the entire amount and some provide no coverage at all. We urge you to be fully aware of the provisions of your insurance and its limitations.

Our services are offered on the understanding that even though you may be covered by insurance, you will be financially responsible for the total amount of your account. This includes the estimated amount not paid by insurance and the balance remaining on your account after the insurance company has made any payment.

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

* I agree to let this office run a credit report. If no, then all fees are due at time of service.

* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due. If sent to collections, I agree to pay all related fees and court costs.

* I understand that I need to give 24-hour notice in advance for any cancellation to my appointment, otherwise I shall be charged $50.00 for every missed appointment.

* Treatment plans may change, and I will be responsible for the work actually done.

Patient Name: _____ Date: _____

Patient Signature: _____

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HIPAA Acknowledgement

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices.

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name: _____ Date: _____

Patient Signature: _____

Updated 2/24/2021

COVID-19 HEALTH SCREENING FORM - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
1. Have you been fully vaccinated for COVID-19? *(If someone is fully vaccinated, they have received both doses of a COVID-19 vaccine, and it has been 14 days since their second dose.)* If **YES,** skip to question 12. You do not need to answer questions 2-11.	☐	☐
2. Do you have a fever or above normal temperature?	☐	☐
3. Have you experienced shortness of breath or had trouble breathing?	☐	☐
4. Do you have a dry cough?	☐	☐
5. Do you have a runny nose?	☐	☐
6. Have you recently lost or had a reduction in your sense of smell?	☐	☐
7. Do you have a sore throat?	☐	☐
8. Have you been in contact with someone who has tested positive for COVID-19? If yes, what was the date? _____	☐	☐
9. Have you tested positive for COVID-19? If yes, what date did you test positive? _____	☐	☐
10. Have you been tested for COVID-19 and are awaiting results?	☐	☐
11. If you have COVID-19, how long have you been free of symptoms?	Provide Date:	
12. Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____ _____

Print Patient Name | Patient Signature (parent if minor) | Date

_____

Witness

Patient Request for Treatment,
Representations and Consent

Responding to the public health hazard posed by Coronavirus disease 2019 ("COVID-19"), effective 5:00 p.m. on Friday, March 27, 2020, Governor Philip D. Murphy ordered and directed the suspension of all surgeries or invasive procedures performed on adults that can be delayed without undue risk to the current or future health of the patient as determined by the patient's treating physician or dentist.

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises

Accordingly, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not, within the past 14 days, travelled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 10 or more persons, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19.

I consent to the performance of the treatment proposed by my dentist.

Name: _____

Signature: _____

Date: _____