Plaistow
Smile Dental

Patient Information Form

Date:_____

Patient Name:_____
DOB:_____Age_____ Sex: Male/Female SS#_____
Street Address:_____
City:_____State:_____Zipcode:_____
Parent/Guardian Address:_____
Phone#_____ Cell:_____
Email:_____ How did you hear about us?_____

EMERGENCY CONTACT:
Name:_____ Relationship:_____
Phone #:_____ Cell:_____

INSURANCE INFORMATION:
Insurance Company:_____ Phone#:_____
ID#:_____Group#_____
Subscriber Name:_____(If different from patient)
Subscriber's DOB:_____SS Number:_____Relationship_____
Employer:_____
If you have secondary insurance please list below:

ASSIGNMENT & RELEASE:
I certify that I, and/or my dependent(s), have insurance coverage with the above name insurance company and assign directly to Plaistow Smile Dental "insurance benefits", if any, for services rendered. I understand that I Am financially responsible for any and all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Above may use my dental information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable.

_____ _____
Signature of Patient, Guardian, Parent: Please Print Name:

Date: _____ Relationship:_____

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Health History

Patient Name(Printed):_____ DOB:_____

Please circle "yes or no" to indicate if you have, or have had any of the following:

AIDS/HIV	Yes No	Epilepsy	Yes No	Respiratory Disease	Yes No
Anemia	Yes No	Fainting or Dizziness	Yes No	Rheumatic Fever	Yes No
Arthritis	Yes No	Glaucoma	Yes No	Scarlet Fever	Yes No
Artificial Heart Valves	Yes No	Headaches	Yes No	Shortness of breath	Yes No
Artificial Joints	Yes No	Heart Murmur	Yes No	Sinus Trouble	Yes No
Asthma	Yes No	Heart Problems	Yes No	Skin Rash	Yes No
Back Problems	Yes No	Hepatitis Type	Yes No	Special Diet	Yes No
Bleeding Abnormally	Yes No	Herpes	Yes No	Stroke	Yes No
Blood Disease	Yes No	High Blood Pressure	Yes No	Swollen Feet/Ankles	Yes No
Cancer	Yes No	Jaundice	Yes No	Swollen Neck/Glands	Yes No
Chemical Dependency	Yes No	Jaw Pain	Yes No	Thyroid Problems	Yes No
Chemotherapy	Yes No	Liver Disease	Yes No	Tonsillitis	Yes No
Circulatory Problems	Yes No	Low Blood Pressure	Yes No	Tuberculosis	Yes No
Congenital Heart Lesion	Yes No	Mitral Valve Prolapse	Yes No	Tumors	Yes No
Cortisone Treatments	Yes No	Nervous Problems	Yes No	Ulcer	Yes No
Cough, Persistant,Bloody	Yes No	Pacemaker	Yes No	Venereal Disease	Yes No
Diabetes	Yes No	Psychiatric Care	Yes No	Weight Loss, severe	Yes No
Emphysema	Yes No	Radiation	Yes No		

Please list your physicians Name, Phone #, address below. _____

_____

Do you wear contact lenses?

Taking Birth Control? Yes No

Are you Pregnant? Yes No Due Date:_____ Are you nursing? Yes No

OB Physician's Name Phone#:_____

Active Tuberculosis:Yes or No ? Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, please list_____

Have you had an orthopedic total joint(hip, knee, elbow, shoulder) replacement?_____

Do you require premedication prior to dental visits?_____

MEDICATIONS

List any medications you are currently taking

_____

_____

_____

_____

_____

ALLERGIES

Circle allergies listed, or others not listed.

Aspirin Latex

Barbiturates (sleeping pills)

Codeine Local Anesthetic

Iodine Penicillin

Other:_____

Patient Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

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General Consent Form

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1.) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment pla.

2.) I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.

3.) In general terms, the dental procedure(s) can include but not limited to:

A. Comprehensive oral examination, radiographs, cleaning of teeth, and the application of topical fluoride.

B. Application of resin "sealants" to groves of the teeth.

C. Treatment of diseased, or injured teeth with dental restorations (fillings).

D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.

4.) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustments and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health services.

5.) I certify that if i, and/or my dependents have insurance coverage i assign directly to the dentist all insurance benefits for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

6.) I have answered all of the questions about me and my dependent's medical history and present health conditions fully and truthfully. I have told the dentist or other personnel about all medical conditions, including allergies. I also understand if my dependent(s) or i ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its consents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name:_____ Date of Birth:_____

Parent/Guardian if patient is Minor_____ Relationship:_____

Signature:_____ Date:_____

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PRIVACY PRACTICES ACKNOWLEDGEMENT/CANCELLATION POLICY

Acknowledgement Form:

I have received the " Notice of Privacy Practices" and have been provided an opportunity to review it.

Patient Signature:_____ Date:_____

Cancellation Policy:

Plaistow Smile Dental organizes your appointment time to ensure you get quality, personalized care and attention. We understand work and family issues happen, however, a 24 hour cancellation policy ensures the office to a full schedule of patients Failure to notify the office reserves the right to a $50 fee and the right to terminate doctor-patient relationship after two(2) failed appointments. If an emergency occurs, we will treat you accordingly.

Patient Signature:_____ Date:_____

Thank you
Plaistow Smile Dental