Time 9:04 AM

SMILE BY DESIGN HARTFORD

Date 7/18/2018

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Smile BY DESIGN

A BRIGHTER SMILE BEGINS HERE

Smile by Design Windsor Adult Patient Registration

Patient's Name: _____

DOB:____/____/____ SS#:_____-_____-_____ Sex: Male / Female

Address:_____ Apt/Unit/Floor: _____

City:_____ State:_____ Zip:_____

Home Phone#: ( )_____-_____ Cell Phone #: ( )_____-_____ Work Phone #:( )_____-_____

E-Mail Address:_____

Whom we may we thank for referring you: _____

Emergency contact: _____ _____ ( )_____-_____

Name Relationship Phone

Insurance Information

Primary Insurance (If applicable)

Name of the policy holder:_____ Relationship to the patient:_____

Employer of the policy holder:_____

Policy holder's Social Security #:_____ Policy Holder's DOB:___/___/___

Insurance Co:_____ Group #:_____ID#:_____

Secondary Insurance (If applicable)

Name of the policy holder:_____ Relationship to the patient:_____

Employer of the policy holder:_____

Policy holder's Social Security #:_____ Policy Holder's DOB:___/___/___

Insurance Co:_____ Group #:_____ID#:_____

Dental History

Date of last visit to a dentist: ___/___/___ For what service? _____

Do you brush your teeth daily? Yes or No / Frequency? _____ Is Dental flossed used? Yes or No / Frequency? _____

Are you experiencing any dental problems? Yes or No If Yes, Explain: _____

Any unhappy dental experiences? Yes or No If Yes, Explain: _____

Is fluoride taken in any form? Yes or No If Yes, Explain: _____

Any unusual speech habit? Yes or No If Yes, Explain: _____

Lost any permanent teeth? Yes or No If Yes, Explain: _____

Have missing teeth been replaced? Yes or No If Yes, Explain: _____

Orthodontic appliances, worn or ever been worn? Yes or No

Any of the following habits:

Lip biting / Mouth breathing / Tobacco use / Tongue thrusting / Nail biting / Mouth odor / Jaw pain / Biting hard objects / Thumb Sucking

Financial Policy

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible to know your Plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as frequency limits for exams, prophylaxis, fluoride and x-rays etc. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, to help you accept an extensive treatment plan we are offering an interest free dental treatment Financing Program. All estimates are subject to final approval by your dental insurance plan; therefore, the amount due is subject to change after final explanation of benefits have been paid.

INITIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam and cleaning, no deductible is due for diagnostic or preventative treatment unless otherwise stated. There are some Plans with coinsurance payment for x-rays and dental exam.

RESIN-BASED COMPOSIT RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment- AMALGAM (silver/mercury based restoration). For our patients' best interests, we only use composite-based ("white") fillings. The difference is usually $30-$90 per filling and the patient is responsible for the difference in cost. Please ask our assistants or doctors if you need more information about composite-based "white" fillings.

PULP-CAP TREATMENT (medicament to protect pulp chamber): Most dental plans do not allow additional benefits for pulp-cap treatment (this procedure in which the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing and repair via formation for secondary dentin). The cost of this treatment is $20- $53 per tooth (depends on your Insurance coverage) and the patient is responsible for payment at the time of treatment. If your Insurance does not cover it or does not allow separate benefits, you will be charged a contracted fee (between us as a provider and The Insurance).

FINANCIAL CHARGES: All returned checks are subject to $25 fee. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.

I understand that payment of a calculated % is due at the time treatment I rendered, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependent(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to Smile by Design any insurance benefits otherwise payable to me.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF SMILE BY DESIGN, LLC.

Patient's Name: _____

Signature: **X** _____ Date: ____/____/_____

Consent for Dental Procedures & Acknowledgement of Receipt of Information

It is the policy of this dental practice to inform parents of all procedures contemplated for you. At each examination appointment we will identify any dental treatment needed and describe this to you. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc. will be performed at a separate appointment after obtaining your permission.

State Law requires that we obtain your written informed consent for any treatment given to you. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it further.

1. I hereby authorize and direct Dr. Saleh Al Kharsa assisted by other dentists and/or dental auxiliaries of his choice, to perform upon myself the following dental treatment or oral surgery procedures, Including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms the dental procedures or operation will include:
    - Cleaning of the teeth and the application of topical fluoride.
    - Application of plastic "sealants" to the grooves of the teeth.
    - Treatment of diseased or injured teeth with dental restoration (filling or caps).
    - Replacement of missing teeth with dental prosthesis.
    - Removal (extraction) of one or more teeth.
    - Treatment of mispositioned (crooked) teeth and/or oral developmental or growth abnormalities.
    - Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1 ½ - 3 hours. Allergic reactions are rare.
    - Use of Nitrous Oxide (laughing gas). This is used to help relax and feel the injection less. This gas is placed over your nose after an explanation is given. Again, this gas is very safe when used in the concentration that we use. The nose piece, as with all treatment, will not be forced upon you.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. Although rare, these risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Saleh Al Kharsa to perform treatment as may be advisable to preserve health and life.

I further understand that any family members may be asked remain in the reception area for the duration of your visit. However, for the initial visit, family members may accompany you to the consultation area. Upon completion of consultation, family members might be requested to return to the reception area.

I hereby state that I have read and understand this consent and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: _____

Signature: X _____ Date: ____/____/_____

Smile by Design Office Policy for Appointments

Definition of a "No-Show" Appointment

Smile by Design defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to their confirmed appointment
- Arrives more than 10 minutes late and is consequently unable to be seen
- Cancels with less than 48 hours' notice

How to Avoid a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 48 hours'** notice to cancel a scheduled appointment

1. Appointment Confirmation

Smile by Design will attempt to contact you via text message, email and confirmation call within one week before your scheduled appointment to confirm. If we are unable to speak with you or confirm your appointment through text or email your appointment **will be cancelled.**

2. Always arrive 5-10 Minutes Early

When you schedule an appointment with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before your appointment.

3. Give 48 Hours' Notice to Cancel

When canceling, or rescheduling your appointment, we require our patients to contact our office no later than 48 hours prior to their scheduled visit. This allows us a reasonable amount of time to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment with another patient. We understand that certain unavoidable circumstances may cause you to cancel within 48 hours, these circumstances will be noted in your patient account.

Consequences of "No-Show" Appointments

If you "No-Show" **2** or more appointments within a year you may dismissed from the practice

1. If you are dismissed from the practice, your remaining scheduled appointments will be cancelled
2. Only emergency treatment will be offered within the first 30 days of dismissal
3. Our practice record transfer form must be completed to transfer your dental records to your new provider

I have read and understand Smile by Designs' "No-Show" policy as describe above

Patient's Name: _____

Signature: X _____ Date: ____/____/___

Acknowledgement of Receipt of Notice of Privacy Practices

~You may refuse to sign this acknowledgement~

I have received a copy of this office's Privacy Practices. (upon request)

Patient's Name: _____

Signature: X_____ Date:____/____/____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Other (Please Specify):_____

Paperwork has been reviewed & verified by:

Employee's initials: Yanette Dominguez

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