Who may we thank for referring you?

Date_____

☐ Friends/Family
☐ Doctor
☐ Internet
☐ Insurance
☐ Walk in
☐ Other

Referring Patient _____ Relationship_____

Source: ☐ Website ☐ Google ☐ Other_____

Be Specific _____

Patient Information

Name_____ _____ _____
Last **First** **Middle**

Date of Birth _____/_____/_____ **SS#**_____-_____-_____ **Gender** ☐ Male ☐ Female

Place of Work: _____ **Occupation:** _____

Marital Status _____ **E-Mail** _____@_____

Address _____
Street Apt#

_____
City State Zip

Phone Numbers Home _____ Cell_____ Work _____

Emergency Contact _____ **Phone** _____

Responsible Party

Name _____ **Date of Birth** _____/_____/_____ **SS#**_____-_____-_____

Address _____
Street Apt# City State/Zip

Phone Numbers Home _____ Cell_____ Work _____

Relationship (Please check one) ☐ Parent ☐ Spouse ☐ Guardian ☐ Other

Insurance Information

Policy Holder _____ **Date of Birth** _____/_____/_____ **SS# / ID #**_____

Relationship to the Patient (Please check one) ☐ Self ☐ Parent ☐ Spouse ☐ Guardian

Policy Holder Address _____
Street Apt# City State/Zip

Insurance Company _____ **Phone** _____

Employer Name _____ **Group #**_____

Do you have any secondary insurance? ☐ Yes ☐No If Yes, Please complete the following

Policy Holder _____ **Date of Birth** _____/_____/_____ **SS# / ID #**_____

Relationship to the Patient (Please check one) ☐ Self ☐ Parent ☐ Spouse ☐Guardian

Policy Holder Address _____
Street Apt# City State/Zip

Insurance Company _____ **Phone** _____

Employer Name _____ **Group #**_____

Patient Dental History

Name of previous dentist_____ **Phone #**_____

What if your main purpose of today's visit? _____

Date of last visit to the dentist_____ **Last cleaning**_____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
2. Are your teeth sensitive to hot or cold liquid/foods?	☐	☐	10. Do you bite your lips or cheeks frequently?		
3. Are your teeth sensitive to sweet liquid/foods?	☐	☐	11. Have you ever had any difficult extractions		
4. Do you feel pain to any of your teeth?	☐	☐	in the past?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐	12. Have you ever had any prolonged bleeding		
6. Clicking in your jaw	☐	☐	following extractions?	☐	☐
7. Pain in your jaw, ear, side of face	☐	☐	13. Do you like your smile?	☐	☐
8. Difficulty in opening, closing or chewing	☐	☐	14. Have you thought about a smile makeover?	☐	☐

Nova Smile DENTAL

MEDICAL HISTORY

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions (if you need more space, please indicate it on the comment section on the bottom of this page).

	Yes	No	
Do you feel tired throughout the day?	☐	☐	If yes, please explain:_____
Have you been told you occasionally snore?	☐	☐	If yes, please explain:_____
Have you or a loved one been prescribed a CPAP Machine?	☐	☐	If yes, please explain:_____
Are you under a physician's care now?	☐	☐	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?	☐	☐	If yes, please explain:_____
Have you ever had a serious head or neck injury?	☐	☐	If yes, please explain:_____
Are you taking any medications, pills or drugs?	☐	☐	If yes, please list : _____
			_____
Do you take, or have you taken, Phen-Fen or Redux?	☐	☐	_____
Are you on a special diet?	☐	☐	_____
Do you use tobacco?	☐	☐	*__Women__ : Are you ☐ Pregnant/Trying to get pregnant ☐ Nursing
Do you use controlled substances?	☐	☐	☐ Taking oral contraceptives

Are you allergic to any of the followings? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other _____

PRIMARY CARE PHYSICIAN AND PHONE NUMBER: _____

Do you have, or have you had, any of the following? Please mark only what is applicable.

☐ Acid Reflux
☐ AIDS/HIV positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Sleep Apnea/CPAP
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

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.

Patient's Name (Please print) _____ Date of Birth _____

Signature of Patient or Guardian _____ Date _____

Nova Smile Dental Care Financial Policy

Appointments: A 48 hour notice is required to cancel appointments. Missed appointments and same day cancellations will be assessed a $50 fee per appointment. We understand that conflicts occur however, the more notice given, the better chance we have to appoint another patient in need of care. We ask that you respect our schedule as we do yours by seeing our patients in a timely manner.

Self-Pay Patients: Payment in full is required at the time services are rendered.

Medicaid Patients: It is your responsibility to confirm your eligibility. If at the time of service you are not eligible for benefits, you will be responsible for ALL charges. The office will allow **2 no show or same day cancellations.** After that we will provide emergency care for 30 days to allow you time to find a new dentist.

Patients with Insurance: Your insurance policy may or may not follow the American Academy of Pediatric Dentistry Guidelines. **It is your responsibility to know your own coverage.** If you do not want us to provide the recommended standard of care for your family, it is your responsibility to notify us. As a courtesy, we will file your claims. Any estimate given to you by the practice is purely an **estimate** and is due at the time of service. Insurance companies do not guarantee any payment until they receive the claim, review it, and approve it according to the specific policy terms. If there is a balance after the insurance payment is received, a bill will be generated and sent to you for immediate payment.

Payment Methods: **COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.** In an effort to provide you with flexible payment options, we have expanded our payment policy. We accept ☐Cash, ☐Personal Checks, ☐Visa, ☐MasterCard, ☐Discover, ☐American Express and ☐CareCredit. Please make your choice for any payment due today, sign below and return to the office prior to treatment. All items returned for non-sufficient funds are subject to a $30 fee. If none of the above apply, please see the office manager. Thank you.

Balances: Balances are to be paid within 30 days of receiving a statement. If balances are not paid in within 90 days, the account will be sent to a collection agency. You will be responsible for any costs incurred to collect including the collection agency fees, court costs, and attorney fees. If you have any questions or concerns regarding your bill, please contact the office.

If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 18% accrued yearly, court costs, and attorney fees, as allowed by law.

Patient's First and Last Name: _____

Patient's Date of Birth: _____

Signature of Patient and/or Guardian: _____

Today's Date: _____

For Office Use Only:

Witness Name: _____

Witness Signature: _____