Chasen Smiles
Family and Cosmetic Dentistry

Exceptional Oral Health through Patient Education

Today's Date ____/____/____

Patient Information

How did you hear about our office? _____ Friend's Name (if applicable) _____

Patient Name _____ (Last Name / First Name) SS# _____ Birthdate ____/____/____

Gender ☐ M ☐ F Nickname _____ How would you like us to contact you? ☐ Phone ☐ Text ☐ Email

Home Phone _____ Cell _____ Email Address _____

Billing Address _____ (Street / City / State / Zip)

Driver's License # (if applicable) _____ When was your last dental appointment? _____

Why did you leave your last dentist? _____ Are you nervous about going to the dentist? ☐ Yes ☐ No

Is there anything specific you would like us to do regarding your teeth or gums? _____

Emergency Contact _____ Phone Number _____

Responsible Party

Name of person responsible for this account (if someone other than yourself) _____ (Last Name / First Name)

Relationship _____ DL# _____ SS# _____ Birthdate ____/____/____

Home Phone _____ Cell _____ Email Address _____

Address _____ (Street / City / State / Zip)

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

PRIMARY

Do you have insurance to assist you with payment? ☐ Yes ☐ No

Subscriber's Name _____

Relationship _____ SS# _____

Birthdate ____/____/____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

SECONDARY (IF APPLICABLE)

Subscriber's Name _____

Relationship _____ SS# _____

Birthdate ____/____/____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices from the office of Chasen Smiles. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that may occur in my treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is posted in the facility for disclosure.

Chasen Smiles reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If there are changes, the office shall provide a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be sent to me.

Additional Disclosure Authorization

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize the disclosure of my protected health information to the individuals or entities indicated below.

Any Member of My Immediate Family ☐ Yes ☐ No
Spouse Only ☐ Yes ☐ No
Cavity Free Board ☐ Yes ☐ No
Other (Please Specify): _____

Name of Patient: _____ Date: _____

_____ Self Mother Father Relative Other: _____
Signature of Patient or Guardian — Relationship to Patient

OFFICE USE ONLY

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

Date: _____

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Reason not given
☐ Needed more time to review Notice of Privacy Practices
☐ Other (specify): _____

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Financial Policy

In our continued commitment to provide the highest quality of dental care to all our patients and to have those services affordable, we are pleased to offer you these financial options and guidelines for payment:

- If you have insurance, we will gladly process your claims. We do require that you pay all estimated patient portions when services are rendered.
- Any outstanding insurance benefits not received by this office within 90 days of date of service will be your responsibility. If you do not have insurance, full payment is expected as services are rendered.
- Every effort will be made to help you with your insurance. The estimated insurance coverage is not a guarantee of payment and the insurance company, not our office, determines the dental benefits you receive. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- For our patients without insurance a 10% cash courtesy will be offered if treatment over $100 is paid in full upon date of service (payment with credit or debit card excluded due to processing fees).
- For procedures involving a laboratory step (i.e. crowns, dentures, night guards), 50% of the total fee is required before the case will be sent to the lab.
- Fees are guaranteed for 90 days from the date of your financial estimate.
- We accept Visa, MasterCard, Discover, personal checks, debit cards and cash.
- Financing is available through Care Credit, which offers interest free payment options for large treatment plans. Ask us for an application.
- Two business days notice is required when re-scheduling or cancelling an appointment. A cancellation fee of $25 per half-hour will be assessed for broken appointments with less than two business days notice.

Office Goal: Our office goal is to provide a comprehensive care plan, followed by a preventative maintenance schedule. We strive to present treatment and financial information prior to appointments, therefore eliminating lingering questions. We make every attempt to provide exceptional care in a comfortable environment. **Welcome to our office!**

Signature

I hereby agree that I am fully responsible for the total payment of all procedures performed in this office. I authorize the dental office to release records to my insurance company as needed for payment of dental benefits. I authorize my insurance benefits, if any, to be paid directly to the dental office.

Signature of Patient or Guardian

Date

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Health Assessment

1. Are any of your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets ☐ Biting Pressure
   Comments: _____
2. Do you have fluoride in your drinking water (i.e. are you on city water)? ☐ Yes ☐ No
3. Does your jaw ever feel sore? ☐ Yes ☐ No
4. Name of Physician: _____ Date of last visit: _____
   Reason for your last visit: _____
5. Have you ever been hospitalized? ☐ Yes ☐ No If yes, please describe: _____
6. Have you taken any medicine during the past two years, including prescriptions, over-the-counter meds, vitamins, and herbal supplements? ☐ Yes ☐ No
   If yes, please list: _____
7. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics or any other drugs? ☐ Yes ☐ No
   If yes, please list: _____
8. Have you ever had a reaction to local anesthetics? ☐ Yes ☐ No
9. Do you have a reaction to metal jewelry or latex? ☐ Yes ☐ No
10. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
11. WOMEN: Are you pregnant or are you trying to become pregnant? ☐ Yes ☐ No
12. Do you smoke or chew tobacco products? ☐ Yes ☐ No

Please check any of the following which you have had or have at present:

- ☐ Alcohol or Drug Dependency
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis or Swollen Joints
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Birth Control Pills
- ☐ Blood Transfusion
- ☐ Cancer or Chemotherapy
- ☐ Cold Sores
- ☐ Congenital Heart Defect
- ☐ Cortisone Medicine (Steroids)
- ☐ Diabetes
- ☐ Emphysema or Bronchitis
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Heart Disease or Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis (Type_____)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Medication for Weight Reduction
- ☐ Mental Health Problems
- ☐ Persistent Cough
- ☐ Pre-Medication for Dental Work
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis/Lung Disease
- ☐ Ulcers or other Gastrointestinal Problems

13. Do you have any medical condition or problem not listed above? ☐ Yes ☐ No
    If yes, please list: _____

To the best of my knowledge, all of these answers are true and correct. If I have any change in my health, or if my medications change, I will inform Dr. Chasen at or prior to my next appointment.

_____ _____
Signature of Patient or Guardian Date

Office Use BP: _____ Pulse: _____ ASA: _____ Allergies: _____ Pre-Med: _____ Initials: _____