



Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience as possible.

Today's Date
Patient Name
Address
City State Zip
Email address
Home Phone No.
Work Phone No.
Cellular Phone No.
Best way to contact you
Birth Date Age Male Female
Married Single Divorced Widowed
Social Security Number
Employer Position
Policy Holder Information
Name SSN
Address
Employer
Date Of Birth

Emergency Contact Information:
Name
Relationship
Phone Number
Address
City State Zip

Who may we thank for your referring you?
Friend's Name
Yellow Pages Sign TV
Website / Internet Search Mail Postcard
Previous/Present Dentist
Other family member seen by us

Consent to Dental Treatment
I, (print name), hereby give Dr. Yaritza M. Wright and staff, my consent to perform dental treatment considered necessary.
I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.
I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.
When treatment plans are presented, the expected insurance payment is an estimate. If for any reason the Insurance Company does not pay the amount estimated, I will be responsible for the difference.
I/we, order to set up an account in this office, give permission to Smiles by Design, PC to review my credit. All accounts are charged 1.5% per month interest (18% per year) 60 days from treatment date.
If it becomes necessary for my account to be turned over to a collection attorney, I will be responsible to pay all costs of collections, including attorney fees.
As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. If insurance has not paid claim within 60 days, patient is responsible to pay for services rendered and then reimbursed when insurance payment is received.
Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. If an extended payment plan is desired, please ask us about the CareCredit program.
We reserve a specific block of time for each of our patients. An appointment with you is a bond of trust that we will be here to serve you. We expect you to be present for each of your appointments. It is extremely difficult to provide you with the kind of treatment that you expect from us with constant short notice changes our schedule. As a result we charge \$25 for all cancellations made less than 24 hours in advance. Verifiable sickness and emergencies will be excluded from this charge.
Patient Signature If a minor, Signature of Parent or Guardian
Date

## HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name \_\_\_\_\_

Why are you now seeking dental treatment? \_\_\_\_\_

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now? \_\_\_\_\_ Yes No

2. Are you now under the care of a physician? \_\_\_\_\_ Yes No

If so, what is the condition being treated? \_\_\_\_\_

3. Have you ever been hospitalized or had a serious illness? \_\_\_\_\_ Yes No

If yes, explain \_\_\_\_\_

4. Have you ever had excessive bleeding following an extraction, or do cuts take long to heal \_\_\_\_\_ Yes No

5. (Women) Are you pregnant? If so, give due date \_\_\_\_\_ Yes No

6. Do you use tobacco in any form? If yes, how much? \_\_\_\_\_ Yes No

7. Do you use alcoholic beverages (more than 2 drinks per day)? \_\_\_\_\_ Yes No

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8. Do you have or have you ever had any of the following?

Tire easily, weakness	Yes No	Ulcers	Yes No
Mitral Valve Prolapse	Yes No	Change in appetite	Yes No
Rheumatic Fever	Yes No	Headaches	Yes No
Heart Murmur	Yes No	Convulsions/epilepsy	Yes No
Chest pain/discomfort	Yes No	Kidney disease	Yes No
Heart surgery	Yes No	Numbness/tingling	Yes No
Heart attack/trouble	Yes No	Dizziness/fainting	Yes No
Artificial heart valve	Yes No	Psychiatric treatment	Yes No
Congenital heart disease	Yes No	Tuberculosis	Yes No
High blood pressure	Yes No	Venereal disease	Yes No
Shortness of breath	Yes No	Emphysema	Yes No
Pacemaker	Yes No	Bruise easily	Yes No
Artificial joints	Yes No	Asthma/hay fever	Yes No
Stroke	Yes No	Anemia	Yes No
Marked weight change	Yes No	Persistent cough	Yes No
Eruptions (rash) hives	Yes No	Blood transfusion	Yes No
Glaucoma	Yes No	Radiation therapy	Yes No
Persistent fever	Yes No	Difficulty breathing lying down	Yes No
Ringing in ears	Yes No	Tumors or growths	Yes No
Arthritis/rheumatism	Yes No	Cancer	Yes No
Frequent nosebleeds	Yes No	Diabetes	Yes No
Sinus problems	Yes No	AIDS/HIV	Yes No
Hepatitis	Yes No	Family history of diabetes	Yes No
Jaundice	Yes No	Thyroid condition/goiter	Yes No

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	Yes No	Sulfa drugs	Yes No
Aspirin	Yes No	Penicillin/other antibiotics	Yes No
Codeine	Yes No	Latex	Yes No
Barbiturates/sedatives/sleeping pills	Yes No	Other allergies _____	Yes No

**10. Are you taking any of the following?**

Antibiotics/sulfa drugs	Yes No	Digitalis/other heart medications	Yes No
Tranquilizers	Yes No	Cortisone/steroids	Yes No
Blood thinners	Yes No	Nitroglycerin	Yes No
Insulin/other diabetes drugs	Yes No	Antihistamines/allergy drugs	Yes No
Blood pressure medication	Yes No	Aspirin	Yes No
Recreational drugs	Yes No	Cold remedies	Yes No
Thyroid medication	Yes No		
		Other medication _____	Yes No

If yes to any of the above, list **name** of medication and **dosage** below:

\_\_\_\_\_  
\_\_\_\_\_

**11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_**

**12. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_**

**13. Have you ever had any serious trouble associated with previous dental treatment? Yes No**

**If so, explain \_\_\_\_\_**

**14. Does dental treatment make you nervous? No Slightly Moderately Extremely**

**15. Date of last dental visit \_\_\_\_\_**

**16. Have you ever been treated for periodontal disease (gum disease)? Yes No**

**If so, when? \_\_\_\_\_**

**17. Do you have or have you ever had any of the following?**

Bleeding, sore gums	Yes No	Sensitive to biting	Yes No
Loose teeth	Yes No	Ortho treatments (braces)	Yes No
Unpleasant taste/bad breath	Yes No	Food impaction	Yes No
Sensitive to hot	Yes No	Biting cheeks/lips	Yes No
Burning tongue/lips	Yes No	Clenching/grinding	Yes No
Sensitive to cold	Yes No	Clicking/popping jaw	Yes No
Frequent blister, lips/mouth	Yes No	Shifting of teeth	Yes No
Sensitive to sweets	Yes No	Difficulty opening or closing jaw	Yes No
Swelling/lumps in mouth	Yes No	Change in bite	Yes No

**Do you use the following?**

Brush	Yes No	How often do you brush _____
Dental floss	Yes No	
Fluoride rinse:	Yes No	My Brush is: soft medium hard
Whitening:	Yes No	

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.**

**Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_**

# Smile Survey

Our office is conducting a survey of our patients. If you would kindly answer a few questions below, it would be greatly appreciated. ☺

How do you feel about your smile?

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If you could change anything about your smile, what would it be? (If you had a magic wand!)

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Is there anything that would keep you from improving your smile? If so, please explain.

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Are you familiar with how today's dentistry can enhance your smile? **Yes / No**

Would you like to learn more about how you can improve your smile? **Yes / No**

Your name: \_\_\_\_\_

## Thank You!

# Protecting your confidential health information is important to us

## Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

## Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

## For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

## Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are able to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

## Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

## Patient Acknowledgement

Patient Name(s) \_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you soon!

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Restrictions

You have the right to request restrictions on certain uses and disclosure of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

## Confidential Communications

You have the right to request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

## Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

## Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if health information record in question was not created by our office, is not part of our records or in the records containing your health information are determined to be accurate and complete.

## Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

## Request a Paper Copy of This Notice

You have the right to obtain a copy of the Notice of Privacy Practices Directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.