



Smile Connections Family Dental, LLC

(Please Print)

Adult Registration

Patient Information

Name, Address, Mailing Address, Date of Birth, Age, Home Phone, Cell Phone, Social Security Number, E-mail, Employer Name, Employer's Phone, Position, Employer Address

Spouse Information, Address, Home Phone, Cell Phone, Social Security Number, Employer Name, Employer's Phone, Position, Employer Address

Responsible Party, Address, Home Phone, Cell Number, Social Security Number, Employer Name, Employer's Phone, Position, Employer Address

Primary Insurance, Insurance Company, Group Number, Phone, Address, Relationship to Subscriber, Subscriber Name, DOB, SS#, Subscriber ID #

Secondary Insurance, Insurance Company, Group Number, Phone, Address, Relationship to Subscriber, Subscriber Name, DOB, SS#, Subscriber ID #

Other Information

Whom may we thank or referring you, Previous Dentist/Phone Number, Emergency Contact/Name/Phone Number, Nearest Relative/Name/Phone Number/Relationship(not living with you), Family Members/Friends seen by us

Patient Signature (Guardian/Responsible Party)

Date

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: <i>Mailing address</i>	City:	State: Zip:
Occupation:	Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: <i>Include area code</i> () Cell Phone: <i>Include area code</i> ()

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)* **Yes No DK**

Active Tuberculosis.....

Persistent cough greater than a 3 week duration.....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? <i>(Check one):</i> DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK	Yes No DK
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ()	If yes, what was the illness or problem?
Address/City/State/Zip:	
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
If yes, what condition is being treated?	_____
Date of last physical exam:	_____

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p><small>(Check DK if you Don't Know the answer to the question)</small></p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia®, Boniva®, Reclast®, Prolia®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p> <p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="text-align: right;">Yes No DK</p> <p>Metals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p>Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: Include area code () _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

FINANCIAL POLICY

Patient Name _____

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- **Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered, is due when services are rendered.**
- **As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 90 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.**

We do not file medical insurance.

Payment may be made by any of the following methods.

CASH

CHECK

CREDITCARD

**Information is available upon request for third party financing through the following:
Care Credit**

- **I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.**
- **I agree to pay any and all unpaid balance on my account.**
- **I authorize all insurance benefits paid directly to Smile Connections Family Dental, LLC.**
- **If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Smile Connections Family Dental, LLC or make payment immediately to Smile Connections Family Dental, LLC.**
- **I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.**
- **A finance charge of 1.5% will begin to accrue after 90 days from the date of service on the unpaid balance of my account even though insurance may be pending.**
- **A fee of \$30.00 will be incurred for each returned check.**
- **I understand and agree that if the amounts for which I am responsible become delinquent, I will pay for all costs associated with the collection process. This includes but would not be limited to collection fees, attorney fees and court cost.**
- **I authorize this office to discuss my account with a spouse, parent, step parent, subscriber of any insurance plan that is requested to be filed on my behalf, or responsible party no matter if I am considered legally to be an adult.**

➤ _____
Signature of Responsible Party

Date

Smile Connections Family Dental

Dr. Philip W. Ezell

Signature Release Statement

Your Signature Is Necessary For Us To:

1. PROCESS ALL INSURANCE CLAIMS;
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELEASE MEDICAL INFORMATION TO INUSRANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORTORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical/dental information necessary to process my claims and I authorize release of the same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and dental benefits, including major medical benefits to which I am entitled to, **Smile Connections Family Dental/Dr. Philip Ezell**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient signature: _____

Patient Full Name(printed): _____

Parent Signature(if minor): _____

Social Security Number: _____ Date of Birth: _____

Date: _____