SK Smith
ADVANCED PERIODONTICS • DENTAL IMPLANTS • FACIAL AESTHETICS

FOR OFFICE USE ONLY:

(PREMED)	(ALLERGIES)	(MEDICATIONS)	(CHIEF COMPLAINT)

PATIENT INFORMATION AND HEALTH HISTORY Today's Date ____/____/_____

Patient's Name (Mr. Mrs. Ms. Dr.) _____
Birth Date (Age) ____/____/_____ ( ) Sex____ Marital Status _____ SS# _____
Home Phone _____ Work Phone _____ Cell Phone _____
Home Address _____
Mailing Address _____
Occupation _____ Employer _____
Business Address _____
Email Address _____
Preferred Contact Method: Phone Call ☐ Email ☐ Text Message (reminders only) ☐

Medical Doctor Name and Address _____
Phone (____) ____- _____Fax (____) ____- _____ Email _____
Date and Reason of Last Visit _____
Pharmacy Name_____ Phone (____) ____- _____Fax (____) ____- _____
If you are completing this form for another person:
Your Name_____ Relationship to Patient _____ Primary Phone (____) ____- _____

General Dentist Name and Address _____
Phone (____) ____- _____Fax (____) ____- _____ Email _____
Date and Reason of Last Visit _____
Date of Last Cleaning _____ Date of Last X-Rays _____
Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION
Name_____ Relationship to Patient _____
Phone Number _____ Address _____

DENTAL INSURANCE INFORMATION

Primary	Secondary
Subscriber's Name _____	Subscriber's Name _____
Relationship to Patient _____	Relationship to Patient _____
Dental Insurance Company _____	Dental Insurance Company _____
Group or Policy Number _____	Group or Policy Number _____
Subscriber's Employer _____	Subscriber's Employer _____
Subscriber's ID# _____	Subscriber's ID# _____
Date of Birth _____	Date of Birth _____
SS# _____	SS# _____

Subscriber's Address (If Different) _____
Address of Dental Insurance Company _____

HEALTH QUESTIONNAIRE

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? _____
Have you required a medical clearance prior to any previous dental treatment? _____
How would you describe your current health? (Excellent, Good, Fair, Poor) Explain _____
Any significant changes to your health in the past 1 year? _____

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

CARDIOLOGY	Yes	No
Damaged Valves in a Transplant Heart**	☐	☐
Infective Endocarditis**	☐	☐
Artificial Heart Valve**	☐	☐
Congenital Heart Problems**	☐	☐
Heart Attack*	☐	☐
Angina Pectoris*	☐	☐
Congestive Heart Failure*	☐	☐
Cardiac Pacemaker	☐	☐
Heart Valve Prosthesis	☐	☐
High Blood Pressure	☐	☐
Heart Murmur/ Irregular Beat	☐	☐
Heart Surgery	☐	☐
Rheumatic Fever	☐	☐
Mitral Valve Prolapse	☐	☐
Arteriosclerosis	☐	☐
MUSCOSKELETAL		
Rheumatoid Arthritis	☐	☐
Arthritis	☐	☐
Joint Replacement	☐	☐
Osteoporosis Therapy	☐	☐

IMMUNOLOGICAL	Yes	No
Autoimmune Disease	☐	☐
Hemophilia/ Anemia	☐	☐
Hepatitis	☐	☐
Liver Disease	☐	☐
Kidney Disease/ Dialysis	☐	☐
Growth or Tumor	☐	☐
Recurrent Infections	☐	☐
Organ Transplant	☐	☐
Cancer*	☐	☐
Chemotherapy/ Radiation	☐	☐
HIV Infection (AIDS)	☐	☐
STDs (HPV)	☐	☐
Cold Sores/ Herpes	☐	☐
MRSA	☐	☐
ENDOCRINE		
Diabetes I or II*	☐	☐
Thyroid Problems	☐	☐
GENERAL		
GERD/ Acid Reflux/ Ulcers	☐	☐
Difficulty Hearing	☐	☐
Glaucoma	☐	☐
Chronic Pain	☐	☐

RESPIRATORY	Yes	No
Sinus Trouble	☐	☐
Persistent Cough	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Sleep Disorder	☐	☐
COPD	☐	☐
Tuberculosis	☐	☐
NEUROLOGICAL		
Stroke*	☐	☐
Epilepsy/ Seizures	☐	☐
Fainting Spells	☐	☐
Paralysis/Numb/ Tingling	☐	☐
Headaches/ Migraines	☐	☐
Alzheimer's	☐	☐
Nervous Condition	☐	☐
OTHER		
Tobacco Use	☐	☐
Alcohol Consumption	☐	☐
Controlled Substances	☐	☐
Dietary Restrictions	☐	☐
Physical Limitations	☐	☐
Currently Pregnant	☐	☐

Additional Comments: _____
_____

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No	Comment		Yes	No	Comment
Local Anesthetics	☐	☐		Iodine	☐	☐	
Penicillin or other Antibiotics	☐	☐		Codeine/ Narcotics	☐	☐	
Sulfa Drugs	☐	☐		Reaction to Metals	☐	☐	
Barbiturates, Sedatives	☐	☐		Latex or Assoc. Foods	☐	☐	
Aspirin	☐	☐		Other	☐	☐	

Do you have any disease, condition or limitation not listed above that you feel we should know about?
_____

Please list all Medications (including OTC), Vitamins, Supplements, Contraceptives, etc. that you are currently taking, or have taken, within the past 6 months. If you require additional room, notate that you are utilizing the back of this page.

Drug	Condition Being Treated	Dosage	Frequency

DENTAL QUESTIONNAIRE

What is the primary reason for your dental appointment today?_____
Please list any other items you would like to review today: _____

Check any of the following which you may have or experienced:

- ☐ Injury to the Face or Jaw
- ☐ Slow Healing Mouth Sores
- ☐ Fever Blisters
- ☐ Mouth Ulcers
- ☐ Swollen Gums
- ☐ Tired Jaw or Sore Muscles
- ☐ Sensitivity to Hot/ Cold
- ☐ Mouth Odor
- ☐ Bad Taste in Mouth
- ☐ Bleeding Gums
- ☐ Clenching/ Grinding
- ☐ Clicking/ Popping in Jaw
- ☐ Jaw Locking Open/ Closed
- ☐ Change in Bite
- ☐ Loose Teeth
- ☐ Orthodontic Therapy
- ☐ Periodontal (Gum) Treatment
- ☐ Oral Surgery
- ☐ Crown/ Bridge Work
- ☐ Difficulty Chewing
- ☐ Dry Mouth

How would you Describe your pattern of dental care ☐ Regular ☐ Sporadic ☐ Infrequent

Which of the following do you use on a regular basis?

- ☐ Manual Toothbrush
- ☐ Powered Toothbrush
- ☐ Floss
- ☐ Toothpicks
- ☐ Proxabrush
- ☐ Night/ Bite Guard
- ☐ End-Tuft Brush
- ☐ Stimudent
- ☐ Rubber Tip
- ☐ Mouthwash (Type)
- ☐ Toothpaste (Type)
- ☐ Removable Appliance
- ☐ Supplemental Fluoride
- ☐ Oral Irrigator
- ☐ Whitening Products
- ☐ Denture Adhesive
- ☐ Tongue Scraper

How often do you brush? _____ How often do you floss? _____
Are you currently experiencing any pain in your mouth? Where? _____
Describe (Ex: Throbbing, Sharp, Consistent, Intermittent, Dull) _____
Are you happy with the appearance of your teeth? _____
Are you apprehensive about receiving dental treatment? _____
What is your main concern? _____
Any complications associated with previous dental treatment? _____
Has any family member had similar periodontal signs/symptoms? _____
Are you interested in more information on the esthetic/ cosmetic procedures we provide? Yes ☐ No ☐

Patients 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 Dentist, or any other member of his/her staff, may not be 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. I also understand that I will have the opportunity to discuss all relevant health issues and/or my medical history prior to treatment.

Patient Signature _____ **Date** _____

Signature of Responsible Party _____ Relationship to Patient _____

For Office Use Only:

Date: _____ Temp: _____ BP:_____ HR: _____ ASA Class: _____
Notes:

Scott K. Smith, D.D.S. 357 S Gulph Road, Suite 250 King of Prussia, PA 19406 610.265.7023

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dr. S. K. Smith ("Dental Office") is required by federal law to provide a Notice of Privacy Practices ("Notice"), which describes how medical information the Dental Practice maintains about patients may be used and disclosed and how patients can access this information.

This Notice is located in the binder titled "Notice of Privacy Practices", which was handed to me by the front desk staff with this form. I acknowledge that the Notice is also available for review at www.drsksmith.com and that I may request a copy of the Notice from the front desk to take home with me. **Please review the Notice carefully.** The Dental Practice may amend the Notice from time to time. All amendments apply retroactively.

By signing below, I acknowledge that I received a copy of the Notice and have been given the opportunity to read and review the Notice.

Patient Signature _____ **Date** _____

Signature of Responsible Party _____ Relationship to Patient _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form is used to authorize the release of my protected health information as required by federal and state privacy laws. I understand that, by signing below, this authorization allows the Dental Practice to release my protected health information to a person or organization I choose. I understand that my treatment may not be conditioned upon my willingness to sign this authorization, unless otherwise permitted by law. I also understand that my health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient(s) and is no longer protected by the Privacy Rule (HIPAA).

Patient Name _____ Date of Birth _____ SSN _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name _____

Complete Address _____

Phone Number _____ Email or Fax Number _____

Extent of Authorization

a. □ I authorize the release of my complete health record (which may include, but is not limited to, records relating to communicable diseases, HIV/AIDS and Hepatitis C, treatment of alcohol or drug abuse, and mental health records (excluding psychotherapy notes)).

OR

b. □ I authorize the release of my complete health record, with the exception of the following information:

Please specify: _____

_____

Purpose of Disclosure: □ At the Request of the Patient □ Other, please specify _____

This Authorization will expire on _____. I understand that I may revoke this authorization at any time by submitting a request in writing to this Dental Practice, at 357 S. Gulph Road, Suite 250, King of Prussia, PA 19406, but such revocation is not effective until delivered to the Dental Practice and is not effective as to health records already disclosed under this authorization.

Patient Signature _____ **Date** _____

Signature of Responsible Party _____ Relationship to Patient _____

FINANCIAL AGREEMENT

Dr. Smith and teams' primary mission is to deliver the finest and most comprehensive periodontal services available today. We want your dental care experience to be as seamless as possible. To best assist you with the investment in your dental health, we have outlined our payment options.

Insurance

Our office will assist you with submitting dental insurance claims to dental insurance plans and companies. We currently participate with PPO's from *Aetna, Cigna, MetLife, Guardian,* and *Delta Dental*. We no longer participate with discount programs. If you believe treatment of diagnosis should be billed to any other (medical) insurance, we will provide you with copies of the dental insurance forms that you can submit to the insurance of your choice. The insurance reimbursement – if applicable – is based on a contract between you and/or your employer and your insurance carrier.

Due to constantly changing insurance regulations, benefits and deductibles, we are only able to approximate your insurance balance. If your insurance pays more than expected, you will be credited the difference. If your insurance company pays less than expected, you will be charged the difference – these fees are expected to be paid in full within 60 days. If payment is not received within 60 days a 1.5% finance charge (18% annually) will be added to any balance.

Insured Payment Options:

20% of the services rendered to be paid at the time appointment is scheduled.

OR

If predetermination has been received by our office, your patient portion will be due in full.

Uninsured Payment Options: These options only apply if you do *not* have dental insurance.

Option 1: 10% off if paid in full at time of scheduling with cash or check only.

This option gives you the maximum savings on the cost of your treatment.

Option 2: 50/50 split – 50% down when scheduling and 50% at time of service (cash, credit, debit, check). We accept MasterCard, Visa, Discover, and American Express.

- *5% off for seniors only (cash, credit, debit, check)

Option 3: Outside financing, for those who would prefer an extended payment plan.

Care-Credit is a credit card specific for any health care treatment. This plan may be used like any other credit card to pay for treatment and or services in our office.

- To utilize this option, your total due must be over $1000.00 and can choose from 24, 36 or 48 months (@ 14.90% current APR until paid in full).

Cancellation Policy: Our office requires two business days or 48 hours' notice for any changes in scheduling. For appointments changed or cancelled under 48 hours' or for no shows, a fee will be accessed in the amount of $100 per hour for any surgical or doctor appointments, or a $75 flat fee for perio-maintenance appointments.

If you have questions regarding your dental insurance or payment policy or procedures, please do not hesitate to ask our staff. They are well informed and up-to-date.

Patient Signature _____ **Date** _____