Smileline
GENERAL & COSMETIC DENTISTRY

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New Patient Health, Consent, COVID 19 Forms

(Must Be Completed Every Visit)

Demographic Information

Patient Information

Preferred Name: _____ First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____ Address: _____

City: _____ State/Province: _____ Zip Code/Postal Code: _____

Preferred Language: _____ Gender: _____

Contact Information

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Preferred Contact Method: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Contact's Relation to Patient: _____

Primary Insurance

Dental Insurance Company: _____ Plan Name: _____

Policy / Group Number: _____ Insurance / Member Id Number: _____

Insured Full Name: _____ Relation To Insured: _____

DOB of Insured: _____ Insurance Provider Phone: _____ SSN of Insured: _____

Secondary Insurance

Insurance Company: _____ Plan Name: _____

Policy / Group Number: _____ Insurance / Member Id Number: _____

Insured Full Name: _____ Relation To Insured:_____

DOB of Insured: _____ Insurance Provider Phone: _____ SSN of Insured: _____

Employer Information

Employer Name: _____ Occupation: _____ How Long With Current Employer?: _____

Address: _____ City: _____ State/Province: _____ Zip Code/Postal Code: _____

Other Information

Referred By: _____ How did you find us? _____ Primary Physician: _____

Dental History

Reason for today's visit: _____ Former Dentist? City & State: _____

Date of last dental visit: _____ Date of last dental X-rays: _____

Please indicate if you have any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between the teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken filling
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ None

How often do you floss? _____ How often do you brush? _____

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.

Signature of Patient, Parent, or Guardian: _____

Health History

Are you under a Physicians care now? ○ Yes ○ No

Have you ever been hospitalized or had a major operation? ○ Yes ○ No

If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No

If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No

If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Do you need to pre-medicate? ○ Yes ○ No

If yes, please explain: _____

Are you...

☐ Pregnant or trying to get pregnant? ☐ Taking oral contraceptives?

☐ Nursing? ☐ N/A

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa drugs ☐ None ☐ Other Other Allergies: _____

If yes, please explain: _____

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

☐ AIDS or HIV Positive	☐ Alzheimers Disease	☐ Anaphylaxis	☐ Anemia
☐ Angina	☐ Arthritis or Gout	☐ Artificial Heart Valve	☐ Artificial Joint
☐ Asthma	☐ Blood Disease	☐ Blood Transfusion	☐ Breathing Problem
☐ Bruise Easily	☐ Cancer	☐ Cell Disease	☐ Chemotherapy
☐ Chest Pains	☐ Cold Sores or Fever Blisters	☐ Congenital Heart Disorder	☐ Convulsions
☐ Cortisone Medicine	☐ Diabetes	☐ Drug Addiction	☐ Easily Winded
☐ Emphysema	☐ Epilepsy or Seizures	☐ Excessive Bleeding	☐ Excessive Thirst
☐ Fainting Spells or Dizziness	☐ Frequent Cough	☐ Frequent Diarrhea	☐ Genital Herpes
☐ Frequent Headaches	☐ Glaucoma	☐ Hay Fever	☐ Heart Murmur
☐ Heart Attack or Failure	☐ Heart Pacemaker	☐ Heart Trouble or Disease	☐ Hemophilia
☐ Hepatitis A	☐ Hepatitis B or C	☐ High Blood Pressure	☐ Herpes
☐ High Cholesterol	☐ Hives or Rash	☐ Irregular Heartbeat	☐ Hypoglycemia
☐ Kidney Problems	☐ Leukemia	☐ Low Blood Pressure	☐ Liver Disease
☐ Lung Disease	☐ Mitral Valve Prolapse	☐ Pain in Jaw Joints	☐ Osteoporosis
☐ Parathyroid Disease	☐ Psychiatric Care	☐ Radiation Treatments	☐ Renal Dialysis
☐ Recent Weight Loss	☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever
☐ Shingles	☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Spina Bifida
☐ Stomach or Intestinal Disease	☐ Stroke	☐ Swelling of Limbs	☐ Thyroid Disease
☐ Tonsillitis	☐ Tuberculosis	☐ Tumors or Growths	☐ Ulcers
☐ Venereal Disease	☐ Yellow Jaundice	☐ None	

Have you ever had any serious illness not listed above? ○ Yes ○ No

If yes, please explain:_____

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.

Signature of Patient, Parent, or Guardian: _____

COVID-19 PRESCREENING

Do you have any of the following symptoms?

- ☐ Fever
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chills
- ☐ Headache
- ☐ Sore throat
- ☐ New loss of taste or smell
- ☐ Myalgias (muscle pain)
- ☐ New onset tiredness/fatigue
- ☐ Congestion or runny nose
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ None

Are you in contact with any people that have been confirmed COVID-19 positive? Patient's who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment. ◯ Yes ◯ No

Did you ever get Covid-19? ◯ Yes ◯ No

If yes the date you tested positive? _____

Date you tested Covid-19 Negative _____

Have you ever received a dose of COVID-19 vaccine? If yes please mention the vaccination and number of doses?

_____

Financial Policy

1. I Authorize the Release of my dental information necessary to process my insurance claim(s).
2. I authorize and request payment of dental benefits directly to smile line.
3. I understand I am financially responsible for any charges whether or not paid by insurance plan and further agree to pay SMILE LINE for any and all patient responsible balances, co-payments, deductibles, and non-covered services indicated by my insurance policy.
4. I understand if mentioned payments in #3 are not paid within 3 months, my balance will be forwarded to a collection company authorized by SMILE LINE DENTAL PRACTICE.
5. I understand that my co-payments are due on the day/time of treatment and/or otherwise any other arrangements discussed with the office manager
6. I agree that a photocopy of this form may be used in place of the original.
7. Any dental records like x-rays,tplan etc requested will take 3 to 5 business days.
8. Panorex fees is $30.00.
9. Missed appointment fees for hygiene is $30.00.
10. Broken appointment with dentist same is $35.00.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Consent for X-rays

During your examination, the doctor may feel that x-rays/pictures will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer treatment. In order to perform x-rays/pictures on any patient our office requires the patients consent for such tests to be performed.

Consent for Treatment

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions. I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment. I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment. I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure. I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider. I confirm that I understand this form and the information contained therein.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

PATIENT CONSENT SUPPLEMENTAL INFORMED CONSENT: Dental Treatment in the Era of COVID-19 Patient

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental healthcare team members and sometimes other patients at all times.

Although the risk to exposure, do you accept the risk and accept the treatment? If yes, please sign.

Signature of Patient, Parent, or Guardian: _____