Smile DESIGNERS

Name_____ Birth Date_____
Last First M.I Preferred Name
Address_____ SS#_____

_____ Driver's License_____
City State Zip

Phone: Home_____
Work_____
Cell_____

Email:_____
Whom may we Thank for referring you to our office?_____
Employer_____
Address_____
_____
City State Zip

Medical Doctors Name_____ Office phone_____
Address_____
_____
City State Zip

(If a Minor) Parent/ Guardian

Relationship to Patient_____ Birth Date_____
Name_____ SS#_____
Last First M.I. Preferred Name Driver's License_____
Address_____ Phone: Home_____
_____ Work_____
City State Zip Cell_____

INSURANCE INFORMATION
(Please present your card for photocopy)

Primary Insurance Dental_____ Medical ____
Policy Holders Name_____
Identification #_____
Employer_____
Insurance Company_____
Address_____
City_____ State_____ Zip_____
Insurance Phone_____
Group #_____ Birth date_____

Primary Insurance Dental_____ Medical _____
Policy Holders Name_____
Identification #_____
Employer _____
Insurance Company_____
Address_____
City_____State____ Zip_____
Insurance Phone_____
Group # _____ Birth date_____

I _____ have received a copy of this office's Notice of Privacy Practices.
(Print Name)

_____ _____
Signature Date

*Smile Designers*

**Dr. Anna Dneprov, D.D.S., M.A.**

# Dental Health History Form

Today's Date _____

**Patient's Name:** First_____ MI_____ Last_____ Preferred Name_____

**Are you experiencing any dental pain now?** ☐ Yes ☐ No

**If yes, please describe**_____

**What are your goals in coming to our practice today?** _____

**What is important to you in a dentist or dental practice?** _____

**What has been your experience with dentist in the past?** _____

**Date of last radiographs (x-rays) and exam** _____

**Date of last hygiene continuing care appointment** *(cleaning or periodontal maintenance)* _____

**Former dentist** _____ **Phone**_____

**Address:** Street_____City_____State____Zip_____

**If you left your previous dentist, what are the reasons?**_____

**Have you had problems with prior dental treatment?** _____

**Have you ever been pre-medicated for dental treatment?** ☐ Yes ☐ No

**If yes, why?** _____

**Have you been anxious about having dental treatment?** ☐ Yes ☐ No

**If yes, would you be comfortable sharing why?** _____

**What concerns do you currently have with your oral health or smile?** *(Check all that apply)*

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings (gold or silver)
- ☐ Old crowns
- ☐ Speech problems
- ☐ Too much gum tissue when I smile
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food get caught in between teeth
  If yes, where? _____
- ☐ Difficulty chewing
  If yes, where? _____
- ☐ Bad breath
- ☐ Other_____

**Have you ever had orthodontic treatment?** ☐ Yes ☐ No

**If yes, when?** _____

**Have you ever had periodontal (gum tissue) treatments, such as deep cleanings, root planning, or periodontal surgery?**

☐ Yes ☐ No **If yes, when?** _____

**Have you whitened your teeth in the past?** ☐ Yes ☐ No **If yes, what method?**_____

**Are you interested in learning more about the following?** *(Check all that apply)*

- ☐ Teeth Whitening
- ☐ Orthodontic treatment
- ☐ Tooth colored fillings
- ☐ Invisalign
- ☐ Dental implants
- ☐ Veneers
- ☐ At-home oral hygiene care
- ☐ How to prevent periodontal disease
- ☐ Periodontal treatment during pregnancy
- ☐ Oral hygiene care for infants and toddlers

**Whom may we thank for referring you?**

☐ One of our valued patients *(name of patient)*_____

☐ Internet ☐ Our Website ☐ Other_____

Please list members of your immediate family who are patients in our practice

_____ _____ _____ _____

*Smile Designers*
**Dr. Anna Dneprov, D.D.S., M.A.**

# Confidential Medical Health History Form

Today's Date _____

**Patient's Name:** First_____ MI_____ Last_____ **Date of Birth**_____

**I. Circle appropriate answer** *(Leave blank if you do not understand the question)*

**1.** ☐**Yes** ☐**No** **Is your general health good?**
If NO, explain_____

**2.** ☐**Yes** ☐**No** **Has there been a change in your health within the last year?**
If YES, explain_____

**3.** ☐**Yes** ☐**No** **Have you ever had any surgeries or hospitalization?**
If YES, explain_____

**4.** ☐**Yes** ☐**No** **Are you being treated by a physician now?**
If YES, explain_____
**Date of last medical exam?** _____**Reason for exam**_____

**5.** ☐**Yes** ☐**No** **Have you ever been pre-medicated for dental treatment?**
If YES, why_____

**6.** ☐**Yes** ☐**No** **Have you ever taken Fen-Phen?** If YES, when_____

**7.** ☐**Yes** ☐**No** **Is there any issue or condition that you would like to discuss with the dentist in private?**

**II. Have you experienced any of the following?** *(Please check Yes or No for each)*

| | | |
|---|---|---|
| ☐**Yes** ☐**No** Chest pain (angina) | ☐**Yes** ☐**No** Blood in stools | ☐**Yes** ☐**No** Frequent vomiting |
| ☐**Yes** ☐**No** Fainting spells | ☐**Yes** ☐**No** Diarrhea or constipation | ☐**Yes** ☐**No** Jaundice |
| ☐**Yes** ☐**No** Recent significant weight loss | ☐**Yes** ☐**No** Frequent urination | ☐**Yes** ☐**No** Dry mouth |
| ☐**Yes** ☐**No** Fever | ☐**Yes** ☐**No** Difficulty urinating | ☐**Yes** ☐**No** Excessive thirst |
| ☐**Yes** ☐**No** Night sweats | ☐**Yes** ☐**No** Ringing in ears | ☐**Yes** ☐**No** Difficulty swallowing |
| ☐**Yes** ☐**No** Persistent cough | ☐**Yes** ☐**No** Headaches | ☐**Yes** ☐**No** Swollen ankles |
| ☐**Yes** ☐**No** Coughing up blood | ☐**Yes** ☐**No** Dizziness | ☐**Yes** ☐**No** Joint pain or stiffness |
| ☐**Yes** ☐**No** Bleeding problems | ☐**Yes** ☐**No** Blurred vision | ☐**Yes** ☐**No** Shortness of breath |
| ☐**Yes** ☐**No** Blood in urine | ☐**Yes** ☐**No** Bruise easily | ☐**Yes** ☐**No** Sinus problems |

**III. Have you had or do you have any of the following?** *(Please check Yes or No for each)*

| | | |
|---|---|---|
| ☐**Yes** ☐**No** Heart disease | ☐**Yes** ☐**No** Surgeries | ☐**Yes** ☐**No** Thyroid disease |
| ☐**Yes** ☐**No** Family history of heart disease | ☐**Yes** ☐**No** Hospitalization | ☐**Yes** ☐**No** Asthma |
| ☐**Yes** ☐**No** Heart attack | ☐**Yes** ☐**No** Diabetes | ☐**Yes** ☐**No** Hepatitis |
| ☐**Yes** ☐**No** Artificial joint | ☐**Yes** ☐**No** Family history of diabetes | ☐**Yes** ☐**No** Sexual transmitted disease |
| ☐**Yes** ☐**No** Stomach problems/ulcers | ☐**Yes** ☐**No** Tumors or cancer | |
| ☐**Yes** ☐**No** Heart defects | ☐**Yes** ☐**No** Chemotherapy | ☐**Yes** ☐**No** Herpes |
| ☐**Yes** ☐**No** Heart murmurs | ☐**Yes** ☐**No** Radiation | ☐**Yes** ☐**No** Canker or cold sores |
| ☐**Yes** ☐**No** Rheumatic fever | ☐**Yes** ☐**No** Arthritis, rheumatism | |
| ☐**Yes** ☐**No** Skin disease | ☐**Yes** ☐**No** Emphysema/lung disease | ☐**Yes** ☐**No** Anemia |
| ☐**Yes** ☐**No** Hardening of arteries | ☐**Yes** ☐**No** Kidney or bladder disease | ☐**Yes** ☐**No** Liver disease |
| ☐**Yes** ☐**No** High blood pressure | ☐**Yes** ☐**No** Stroke | ☐**Yes** ☐**No** Eye disease |
| ☐**Yes** ☐**No** Seizures | ☐**Yes** ☐**No** Eating disorders | ☐**Yes** ☐**No** Transplants |
| ☐**Yes** ☐**No** Cosmetic surgery | ☐**Yes** ☐**No** Osteoporosis | ☐**Yes** ☐**No** Tuberculosis |

**This information will not be released unless specifically authorized by patient.**

☐Anxiety ☐Depression ☐Treatment for emotional condition ☐Contagious diseases or disabilities

**IV. Are you allergic to or have you had a reaction to any of the following?** *(Please check Yes or No for each)*

| | | |
|---|---|---|
| ☐**Yes** ☐**No** Aspirin | ☐**Yes** ☐**No** Valium | ☐**Yes** ☐**No** Tetracycline |
| ☐**Yes** ☐**No** Darvon | ☐**Yes** ☐**No** Demerol | ☐**Yes** ☐**No** Vicodin |
| ☐**Yes** ☐**No** Codeine | ☐**Yes** ☐**No** Penicillin | ☐**Yes** ☐**No** Percodan |
| ☐**Yes** ☐**No** Latex | ☐**Yes** ☐**No** Food | ☐**Yes** ☐**No** Nitrous oxide |
| ☐**Yes** ☐**No** Local anesthetic (Novocain or Xylocaine) | ☐**Yes** ☐**No** Erythromycin | ☐**Yes** ☐**No** Metal |

**Others**_____

**V. Are you taking or have you taken any of the following in the last three months?** *(Please check Yes or No for each)*

| | | |
|---|---|---|
| ☐**Yes** ☐**No** Recreational drugs | ☐**Yes** ☐**No** Tobacco in any form | ☐**Yes** ☐**No** Antibiotics |
| ☐**Yes** ☐**No** Over-the-counter medicines | ☐**Yes** ☐**No** Alcohol | ☐**Yes** ☐**No** Supplements |
| ☐**Yes** ☐**No** Weight loss medications | ☐**Yes** ☐**No** Bisphosphonate | ☐**Yes** ☐**No** Aspirin |
| ☐**Yes** ☐**No** Cortico - Steroids | (Fosamax/Boniva) | |

**Please list all medications you are currently taking**_____

**VI. Women only** *(Please check Yes or No for each)*

☐**Yes** ☐**No** Are you or could you be pregnant? If YES, what month?_____

☐**Yes** ☐**No** Are you nursing?

☐**Yes** ☐**No** Are you taking birth control pills?

**VII. All patients** *(Please circle Yes or No for each)*

☐**Yes** ☐**No** **Do you have or have you had any other diseases or medical problems NOT listed on this form?**

If YES, explain_____

**If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.**
**I authorize the dentist to contact my physician.**

Patient's Signature_____ Date_____

Physician's Name_____ Phone Number_____

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

**Medical updates**

I have reviewed my Health History and confirm that it accurately states past and present conditions.

| **Date** | **Patient Signature** | **Changes to Health History** | **Dentist Initials** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**FINANCIAL POLICY**

Welcome! Thank you for selecting us as your dental health care provider. We want you to feel welcome and as comfortable as possible throughout our relationship. We share the concern of our patients about the increasing costs of dental care. We encourage you to ask questions and be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy. Our fees are comparable to the usual and customary charges made by like providers in the area. These charges are based on cost, time and skill involved.

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. Your estimated co-payment will be due at the time of service. Please remember that insurance estimates are based on information provided by you and your insurance company. The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay.

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
3. Services cannot be provided on the assumption that the charges will be paid by the insurance company, therefore, the patient is responsible for the bill, regardless of insurance.
4. If your insurance has not paid in 60 days of services rendered a 21% interest will begin to accrue on the unpaid balance. If you choose to pay the balance in full, the insurance monies will be refunded promptly to you.

**Our doctor will diagnose treatment based on your dental health not your insurance coverage.**

Patients without insurance coverage are requested to pay their charges at the time service is provided. We accept cash, check, all major credit cards as well as CareCredit and CitiFinancial.

Optional payment terms:

- Payment in full cash discount: We offer a 5% courtesy discount with payment of cash or check.
- Term Loan: By arrangements with CareCredit and/or Citi Health card we can offer patients upon approval, an interest free term loan up to 12 months.

We reserve the right to charge a $50.00 fee for all returned checks.

In order to serve you and keep the cost of dental care down, we maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. There will be a charge of $100 per hour for a missed appointment with the doctor and $50 for a missed appointment with the hygienist if not cancelled within 48 hours of any scheduled appointment.

I hereby assign to Dr. Anna Dneprov, the insurance benefits which are otherwise payable to me for the charges and direct that insurance payment be made directly to the office. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure payment.

**Name of Patient (Print)**_____
**Signature of Responsible Party**_____Date:_____

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