Welcome To Our Office, Just Clean Smiles!

Patient Information

Patient Name: _____ Date: _____

Male _____Female_____ Married_____ Single _____ Child (under 18 years) _____ Other_____

If child, Parent/Guardian Name: _____

Patients Social Security #: _____ Patients Birth Date: _____

Telephone: Home_____ Work_____ Cell_____

Address: _____

City, State, Zip Code: _____

Employer: _____

How did you hear about us? _____

Insurance (Please have your ID card ready and we will copy all information needed to file a claim with your insurance company.)

Consent for Internet Communications

E-mail Address: _____

Dental Health

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist: _____ When was your last visit? _____

When was your last cleaning? _____ When was the last time you had x-rays? _____

Please circle Yes or No:

Y N I am having discomfort in my mouth.
Y N I have problems eating.
Y N I like my smile.
Y N My gums bleed while brushing or flossing.
Y N My gums feel tender or swollen.
Y N I clench or grind my teeth.
Y N I prefer tooth-colored fillings.
Y N I have had a facial or jaw injury.

Health Information

Have you ever had any of the following? Please check only those that apply:

_____Arthritis
_____AIDS/HIV
_____Abnormal Bleeding
_____Anemia
_____Asthma
_____Angina
_____Cancer
_____Chemotherapy
_____Radiation Treatment
_____Ulcers
_____History of Drug/ Alcohol Addiction
_____Hearing Loss
_____Sinus Trouble
_____Infectious Mononucleosis (Mono)
_____ Implants/Artificial Joints
_____Emphysema
_____Frequent Headaches
_____Sickle Cell Disease
_____Acid Reflux/GERD

_____Chest Pains
_____Fainting
_____Glaucoma
_____Heart Disease
_____Heart Murmur
_____Mitral Valve Prolapse
_____Congenital Heart Lesions
_____Abnormal Blood Pressure
_____Artificial Heart Valve
_____Liver Disease
_____Eating Disorders
_____Smoke Tobacco
_____Frequent Urination
_____Herpes
_____Blood Transfusion
_____Difficulty Breathing
_____Psychiatric Problems
_____Facial Surgery
_____Osteoporosis

_____Rheumatic Fever
_____Stroke
_____Tuberculosis (TB)
_____Thyroid Problems
_____Pacemaker
_____Epilepsy/Seizures
_____Hepatitis Type___
_____Diabetes
_____Kidney Disease
_____Sexually Transmitted/Venereal Disease
_____Immune Suppressed Disorder
_____Hay fever
_____ Nervous Disorder
_____Have you ever taken Fen-Phen or Redux?
_____Colitis
_____Fever Blisters
_____Shingles
_____Hemophilia

_____Have you been told by your medical doctor to take antibiotics prior to dental treatment?
_____Major surgery: Year_____Type of operation_____
Year _____Type of operation_____
_____ Are you pregnant? How many weeks? _____ Are you nursing? _____
_____Other: List any other medical problem or medical history NOT listed on this form_____
_____

Are you allergic to any of the following? Please check only those that apply:

_____Aspirin _____Ibuprofen _____Sulfa Drugs/Sulfites/Sulfides _____Penicillin _____Codeine
_____Erythromycin _____Tetracycline _____Local Anesthetics (Novocaine) _____Latex, Metals, Plastics
_____Seasonal allergies _____Other Medications: Which ones? _____

List all medications you are currently taking. Please include vitamin supplements. Amounts are not necessary. If you have a list we can copy it for you.

Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____

Medical Doctor/Physician or Clinic: _____Telephone: _____
Address (if available): _____

In the event of an emergency please contact:

Name_____Relationship_____Telephone_____

The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Office Policies and Dental Treatment Consent

Health Information

I agree to disclose all previous illnesses and medical history fully and truthfully. Undisclosed medical information, current medications, allergies or illness are risk factors. Treatment will not be performed if adequate information is not given.

Drugs, latex and medicines

I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases the heartbeat and, depending on my health, may be dangerous to me. Fluoride treatments are standard protocol. Medication is only prescribed when absolutely necessary. **Medications that are prescribed must be taken as directed.**

Radiographs (Xrays)

I understand that radiographs must be taken as necessary for treatment. Treatment may not be performed if radiographs are refused.

Fillings

Care must be exercised in chewing on filled teeth, especially on large fillings and during the first 24 hours, to avoid breakage. A more extensive restorative procedure than originally diagnosed may be necessary, due to more decay than anticipated. Sensitivity can occur following a newly placed filling; this likely will occur if the bite is premature. If this occurs, I will contact the office to have the tooth evaluated.

Crowns and Bridges

These restorations involve permanent alteration of the tooth structure. It is not always possible to match the color of the natural teeth exactly with artificial teeth. Temporary restorations may come off easily. Care must be taken to insure that they are kept on until the permanent restorations are delivered. It is necessary to keep the appointment for permanent cementation. Excessive delays may allow for tooth movement, necessitating the remaking of the restoration and additional charges may be incurred.

Porcelain crowns, veneers, cosmetic bonding and composite fillings are aesthetically pleasing; however, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

Gum Treatments and Requesting "Just a Cleaning"

If I don't floss or if I smoke, I can expect to have a deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis). A cleaning would be less than optimal care. I am aware that treatment may be refused if I request less than optimal care.

Extractions and Surgery

Teeth may be extracted for various reasons, such as non-restorability, lack of bone support, part of orthodontic treatment, impactions, etc. Removal of teeth does not always remove the infection, if present, and further treatment may be necessary. There are risks involved in having teeth removed, including, but not limited to pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue and surrounding tissues, sinus involvement and jaw fracture. If complications arise during or following treatment, referral to a specialist may be needed, requiring further treatment and additional cost.

Dentures (Full and Partial)

The wearing of dentures can be difficult. Several appointments are necessary to fabricate a denture or partial. Sore spots, altered speech and difficulty in eating are common problems. Due to jaw ridge loss, retention of full dentures can be a problem. Immediate dentures may require considerable adjustments and several relines. A permanent reline will be needed later (this may or may not be included in the denture fee). You are responsible to return for all appointments leading up to the delivery of the dentures. Failure to do so may result in poorly fitting dentures and remakes will require additional charges. Failure to wear partial dentures every day will likely lead to tooth movement, resulting in a partial that no longer fits. The office is not responsible for dentures and partials that are not worn.

Fee for Additional or Specialty Care

I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

Children (under the age of 18)

Children must be accompanied throughout the appointment period by a parent or legal guardian. A child may not be dropped off and left without a parent or legal guardian being present during treatment. If a parent or legal guardian must leave the child, arrangements must be made for the parent or legal guardian to leave a signed *Consent to Treat Form* with the practitioner. Only the patient receiving treatment and one other person (parent or legal guardian) will be allowed in the treatment area. Other individuals accompanying the patient must wait in the reception area unless a practitioner specifically gives permission for others to enter. Children usually respond better to treatment when a parent or legal guardian remains in the reception area during treatment however we understand the exceptions.

24 Hour Notice for Cancellation

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives you from receiving care that is needed and deprives our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning, 24 hour advance notification, to keep a scheduled appointment, will result in a $35.00 late cancellation fee being charged. I understand that leaving a message after the office is closed for the day (or weekend) before is NOT sufficient notice. This charge is to be paid by the patient prior to the scheduling of any new appointment. The office reserves the right to dismiss the patient with repeated broken appointments. We may call to confirm your appointment time. This is a courtesy our office provides. It is ultimately your responsibility to be aware of your appointment.

Requesting Record Transfers

I agree not to request records until I have a new dentist. An *Authorization to Release Radiographs* must be signed by the patient or legal guardian if patient is under 18 years of age.

Hygiene Appointments

The assessment received by the dental hygienist does not constitute a comprehensive dental examination. The patient should be seen by a dentist on an annual basis. If it has been indicated that further dental treatment is needed the patient should seek care by a dentist.

Limitations of Insurance Coverage

There are charges beyond what insurance will pay, (e.g. temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work). As a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. ***I agree to be financially responsible for what insurance does not cover.***

Payment is expected when services are rendered. Only checks, cash, and credit cards are accepted as payment. Insurance and Medicaid will be accepted from eligible patients. If payment is not rendered at the time of services, we reserve the right to discontinue treatment. If patient chooses not to return to complete treatment, fees are not refundable.

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during the examination, but were found during the course of treatment. Any change in treatment plan may result in additional fees.

I authorize *Just Clean Smiles* to release any information including diagnosis and the records of any treatment or examination rendered during the period of such dental care to third payors and/or health practitioners.

I authorize and request my insurance company to pay directly to *Just Clean Smiles* insurance benefits otherwise payable to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have read, understand and agree to comply with the above policies.

Signature: _____ Date: _____

Print Your Name: _____

Relationship to Patient: _____

Preferred method of our office contacting you:

Telephone message (specify land or cell phone)_____

Texting_____

Email_____

Discrimination is Against the Law

Just Clean Smiles, LLC

complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Just Clean Smiles, LLC

does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Just Clean Smiles, LLC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Donna Riordan-Kerr.

If you believe that Just Clean Smiles, LLC

Has failed to provide these services or has discriminated in any other way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.