I Smile Dental Care

Patient Information

Last:_____ First:_____ Middle:_____ Male: ☐ Female: ☐

Address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____ E-mail: _____ Birth date: _____

Check appropriate box: Minor: ☐ Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐

Who may we thank for referring you? _____

Person to contact in case of an emergency:_____ Phone:_____

Responsible Party

Name of person responsible for this account

Last:_____ First:_____ Middle:_____ Male: ☐ Female: ☐

Address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____ E-mail: _____ Birth date: _____

Driver's license #: _____ Social security #:_____ Currently a patient in our office: Yes No

Employer:_____ Work phone: _____

Primary Insurance

Name of insured: _____

Relation to patient:_____ Birth date:_____ Social security #: _____

Last:_____ First:_____ Middle:_____ Male: ☐ Female: ☐

Employer:_____ Work phone:_____ Date employed:_____

Employer address:_____ City:_____ State:_____ Zip:_____

Insurance company:_____ Group #:_____ Patient ID #:_____Union or local #:_____

Secondary Insurance

Name of insured: _____

Relation to patient:_____ Birth date:_____ Social security #: _____

Last:_____ First:_____ Middle:_____ Male: ☐ Female: ☐

Employer:_____ Work phone:_____ Date employed:_____

Employer address:_____ City:_____ State:_____ Zip:_____

Insurance company:_____ Group #:_____ Patient ID #:_____Union or local #:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my insurance.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

I Smile Dental Care

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam:_____ What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care?(Please circle) No Yes If yes, nature of care:_____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____

2. _____

3. _____

4. _____

For the following questions circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No Yes	Hepatitis, Any Form	No Yes
Arthritis, Rheumatism or other inflammatory disease?	No Yes	Joint Replacement? When placed?	No Yes
Asthma	No Yes	Kidney Disease	No Yes
Abnormal Bleeding from a cut?	No Yes	Liver Disease (including Jaundice)	No Yes
Cancer or Tumor?	No Yes	Sore/Enlarged Lymph Nodes	No Yes
Diabetes	No Yes	Psychosis	No Yes
Emphysema or other Respiratory/Lung Illnesses	No Yes	Previous Biopsies	No Yes
Epilepsy	No Yes	Radiation or Chemotherapy Treatment	No Yes
Fainting or Dizzy Spells	No Yes	Rheumatic Fever	No Yes
Glaucoma	No Yes	Slow-Healing Mouth Sores	No Yes
Abnormal Heart or Previous Bacterial Endocarditis	No Yes	Unintentional Weight Loss/Gain	No Yes
Heart Valve (artificial) or Heart Transplant	No Yes	H.I.V. Infection/AIDS or ARC	No Yes
Congenital Heart Disease	No Yes	Venereal Disease	No Yes
Heart Disease, Heart Attack, Heart Surgery	No Yes	Other Conditions	No Yes
Heart Stent? When placed?	No Yes	Recurrent Illnesses	No Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No Yes
Antacids?	No Yes	Cardizem® (diltiazem) or Calan, Isoptin®(Verapamil)?	No Yes
Dilantin® or Tegretol®	No Yes	Serzone® (nefazodone) No Yes	
Barbiturates (any)	No Yes	Diflucan® (fluconazole) or Sporonox®(itraconazole)	No Yes
St. John's Wort or Kava-Kava?	No Yes	Biaxin® (clarithromycin) No Yes	
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?			No Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?			No Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?			No Yes

HEALTH HISTORY *(continued...)*

Please list any medications you are currently taking and dosages:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes Are you taking birth control pills? No Yes

Abnormal Blood Pressure? *(Please circle)* No Yes
Have you ever received a diagnosis of "high blood pressure"?
What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:
a. Local anesthetics ..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin, Ibuprofen or Tylenol ..... No Yes
d. Codeine, Valium® or other sedatives..... No Yes
e. Latex or Metals
f. Other (please specify)_____

Tobacco, Alcohol, Drugs
Do you use tobacco? No Yes If yes, circle type: smoke / chew How much per day?_____ For how long?_____
Do you want to quit using tobacco? No Yes
Do you consume alcohol? No Yes If yes, approximately how many alcoholic beverages per week? _____
Do you use any mood altering drugs other than those previously listed? No Yes

Weight and Diet considerations
Weight_____ Meals per Day_____ Dietary Restrictions Food Allergies_____
Sugar in your diet (circle one): *none / slight/ moderate/ high*

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*

DOCTOR'S USE ONLY
Comments on patient interview concerning medical history:
_____
_____
Significant findings from questionnaire or oral interview:
_____
_____
Dental management considerations:
_____
_____

GENERAL DENTISTRY INFORMED CONSENT

DENTIST:..... **PATIENT:**.....

1.- WORK TO BE DONE

I understand that I am having the following procedures performed: Fillings ( ), Crowns( ),Bridges( ), Extractions( ), Root Canals( ), Periodontal Treatment( ), Dentures( ), Orthodontic Treatment ( ), Others( ) (Initials : .....)

2. DRUGS AND MEDICATION

I understand that antibiotics, anesthetics, analgesics and other medications can produce allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Some medications that I might be currently taking could produce undesired effects or interfere with the normal process of healing (for example aspirin could produce excessive bleeding during extractions, etc). I understand that filling the health questionnaire out to the best of my knowledge is important in order to be prepared for any recommended procedure. (Initials : .....)

3. CHANGES IN TREATMENT PLAN

I understand that during the treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. For example, I may need root canal therapy following routine restorative procedures or extraction of a tooth previously treated with root canal treatment. The dentist will explain all changes. (Initials : .....)

4 REMOVAL OF TEETH

Alternatives, benefits and consequences to the removal of teeth (root canal therapy, crowns, and periodontal surgery) have been explained to me and I authorize the dentist to remove the following teeth .....If any others extractions are necessary the dentist will explain it according to the paragraph #3 before the procedure. I understand that removing teeth may not always remove all the infection present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility (Initials : .....)

5. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may cause tooth movement or recurrent decay. This may necessitate a remake of the crown, bridge, or cap. I understand that a root canal may be needed, even though the tooth may not have hurt prior to the crown or bridge having been done. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that the remaking of existing crowns or bridges imply certain risks like pulp involvement, fracture of root, etc; that could lead to further unexpected procedures.(Initials : .....)

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling may extend beyond the tooth root which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all effort to save it. (Initials: .....)

7 PERIODONTAL TREATMENT

I understand that I have a condition, causing gum and bone inflammation that can lead to the loss of teeth. Alternative treatment plans have been explained to me, including Deep cleaning, gum surgery, locally administered antibiotics, bone replacements and/or extractions. I also understand that the success of the periodontal treatment depends not only on the procedure performed but also on the daily personal care.(Brushing and flossing) (Initials: .....)

8. FILLINGS

I understand that care must be exercised in chewing on new fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the fillings being done. I understand that sometimes it is not possible to match the color of natural teeth exactly with white fillings (Composites) especially when replacing existing metal fillings. (Initials : .....)

9. DENTURES

Sore spots, altered speech, and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. I understand that (Initials : .....)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot completely guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient (Parent or Guardian) ..... **Date** .....

Signature of Doctor:..... **Witness**.....

I Smile Dental Family Care

84-18 37th Avenue

Jackson Heights, NY 11372

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for _____this ____day of _____, 20____
A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
PLEASE PRINT YOUR NAME (letra de molde)

X _____
PLEASE SIGN YOUR NAME (firma)

Authority: _____

Thank you and if you have any questions about this form or the attached Notice, please contact a member of our staff.

OFFICE USE ONLY

I attempted to obtain the patients (or representatives) signature on this Acknowledgement but did not because:

___ it was for emergency treatment
___ I could not communicate with the patient
___ The patient refused to sign
___ The patient was unable to sign because, _____
_____

___ Other (Please describe) _____
_____