Universal Smiles Dentistry
1025 South Volusia Avenue
Orange City, FL 32763
(386) 775-993

About You

Name____Married___Single___Male___Female____

Birth Date:_____/_____/_____ SS#______-______-_______Drivers License #_____________________________

Address:____Email:______________________________________

____Phone:_____________________________________

____Cell:_______________________________________

Employer:____Occupation:_________________________________

Employer Address:___________________________________Employer Phone:______________________________

Who May We thank for referring you:____

Dental Insurance

Insurance Company Name:_______________________________________Policy #:__________________________

Company Address:____Phone:____________________________

____

Insureds Name:_______________________________________Relationship to patient:_______________________

Insureds DOB:_____/_____/_____ Insureds SS#:______-______-_________Are you listed on Policy: Y / N

Insures Employer Name and Phone Number:____

Responsible Party

Person Financially Responsible for Account:____

Relationship to Patient:____Phone:___________________________

Billing Address:____Payment:**Payments are expected to be made when services are rendered. We accept credit cards and offer several no financing options**.

____

Medical History

Do you have a personal primary care physician? Y / N Name:____

Phone:____Date of last Exam: _____/_____/_____

Your Current Health:_____Good_____Fair_____Poor Explain:____

____

HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Help in my treatment
- Educate the Doctors who will be performing my treatment
- Only accessed by people with a need to know basis.

I have been informed by you of your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of privacy practices prior to signing this consent form. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at anytime at the address below to obtain a current copy of the notices of privacy practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to care out treatment, payment or health operations. I also understand the organization is not required to agree to my request restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Printed Name:____

Signature: (parent of legal Representative for patient)

____Date:______________________

Inquires to be made to: Universal Smiles Dentistry, 61025 South Volusia Avenue, Orange City, FL 32763. (386) 776-9933.

FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement:

Patients are expected to pay for your services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of there estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa and MasterCard. We also offer zero percent financing that is available for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charged at 18% per year after 90 days.

Appointments:

In order to serve you better and keep the cost of dental care down, we try to 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. We require at least 24 hours notice for any cancelled appointment or you may be subject to a $35 charge. After 3 missed appointments or cancellations we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice.

Insurance Information

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. In order to do this, we need your insurance card and/or insurance policy with your first visit every calendar year. (Your insurance year may not run Jan-Dec.)

All of our doctors will diagnose treatment on your dental health, not your insurance coverage

You must realize that dental insurance isn't really insurance, it is actually a money benefit, typically provided by an employer, the help their employees pay for routine dental services. The employer usually buys a plan based on the amount of benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquires. The insured has a better ability to deal with insurance companies and the employer is responsible for the policy.

Please indicate your understanding and acceptance of these polices by signing below. For the mutual convenience of you and the practice, it is understood that his executed copy of the Policies also shall cover dependent children who are patients of the practice.

Patients Name: (Please Print)____

Patients Signature:____Date:________________________

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MEDICAL DENTAL HISTORY FORM

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Patient Name:
Patient ID #:

Medical Clinic ____________________

Physician____________________

Allergies to:
Latex: Yes No
Medications ____________________
Other ____________________

PreMed required? Yes No

Reason: ____________________

Type: ____________________ Dosage: ____________________

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes
8 Under physician's care?	
Details:	
9 Hospitalization/operation(s) in last 5 years?	
Details:	
10 Head/neck/mouth injuries?	
11 Women: pregnant?	
12 Women: nursing?	
13 Women: oral contraceptives?	
14 Heart trouble/disease?	
15 Rheumatic fever?	
16 Past use of Fenphen?	
17 Heart murmur?	
18 Mitral valve prolapse?	
19 Heart surgery?	
20 Artificial heart valves?	
21 Pacemaker?	
22 Indwelling defibrillator?	
23 Artificial joints?	
24 History of Organ Transplant?	
25 High blood pressure? BP: /	
26 Stroke?	
27 Bleeding problem?	
28 Hemophilia?	
29 Anemia?	
30 Leukemia?	
31 Lung disease?	
32 Emphysema?	
33 Shortness of Breath?	

	Yes
34 Asthma?	
35 Sleep Apnea?	
36 Tuberculosis?	
37 Sinus trouble?	
38 Cancer?	
39 Radiation Treatment to Head/Neck?	
40 Chemotherapy?	
41 Kidney Disease?	
42 Dialysis?	
43 Eating Disorder?	
44 Stomach: reflux? ulcer?	
45 Immunological disease?	
46 Sjogrens Disease?	
47 Fibromylagia?	
48 Other autoimmune disease (lupus, pemphilus)?	
49 Arthritis or other joint disorders?	
50 Diabetes? Type: Controlled? Y N	
51 Headaches?	
52 Depression: Diagnosed?	
53 Other Psychiatric Disorders?	
54 Neurologic Disease?	
55 Convulsions?	
56 Epilepsy/seizures?	
57 Cerebral Palsy?	
58 Fainting/dizziness?	
59 Venereal disease?	
60 AIDS/HIV positive?	
61 Alcohol or chemical dependency?	
62 Hepatitis?	
63 Thyroid disease?	
64 Glaucoma?	

TOBACCO

	Yes
65 Tobacco user?	
Type:	
Amount:	
Number of years:	
66 How soon after wake up do you use tobacco? <30 minutes >30 minutes	
67 Previous attempts to quit?	
Number of attempts:	
Longer period of success:	
Methods used:	
68 Are you interested in quitting tobacco?	
69 Former tobacco user?	
Type:	
Amount:	
Year quit:	

DENTAL INFORMATION:

70 Previous dentist:	
71 Last dental visit:	
72 Last dental cleaning:	
73 Frequency of dental exams:	
74 What made you decide to make this dentist appointment?	
75 Frequency of brushing:	
76 Frequency of flossing:	
77 What are some typical foods you eat between meals?	
78 What types of beverages do you typically drink between meals?	
79 How often do you chew or suck on hard candy, cough drops or mints?	
80 Do you use fluoridated toothpaste?	Yes
81 Primary source of drinking water? (circle) City water filtered City water unfiltered Bottled water Well water	

PAST DENTAL TREATMENT:

	Yes
82 One or more fillings in the last three years?	
83 Family history of extensive decay?	
84 If Child, mother's history of decay?	
85 Treatment for periodontal (gum) disease?	
86 Family history of periodontal disease?	
87 Have you had orthodontics (braces)?	
88 Have you had oral surgery?	
89 Have you had any dental implants placed?	
90 Treatment for tempormandibular disorders?	
91 Do you wear a denture(s) or partial denture(s)?	

DO YOU HAVE CONSISTENT PROBLEMS WITH:

92 Dry mouth/excessive thirst?	
93 Sensitive teeth? Hot Cold Pressure Sweets	
94 Mouth odors/bad taste?	
95 Cold sores/blisters/oral lesions?	
96 Are you aware of any swelling or lumps?	
97 Sore, bleeding gums?	
98 Loose teeth?	
99 Difficulty chewing?	
100 Food catches between teeth?	
101 Teeth/filling break frequently?	
102 Clenching or grinding habits?	
103 Do you hear popping, clicking or snapping?	
104 Do you have jaw pain?	
105 Are you nervous about dental work?	

Patient Signature:____ Date:______________

For Office Use Only

Dental Provider Acknowledgement:

I have reviewed the above medical, dental and social histories with the patient and have complete and accurate information to provide a clinical diagnosis and recommend appropriate treatment options.

Provider Signature: ____ Date: ______________