



Universal Smiles Dentistry  
6735 Conroy Windermere Road, Suite #202  
Orlando, FL 32835  
(407) 910-1178

## 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, 6735 Conroy Windermere Road, Suite #202, Orlando, FL 32835. (407) 910-1178.



## 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 their 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, that helps 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 policies 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: \_\_\_\_\_

**MEDICAL DENTAL HISTORY FORM**

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		Yes
8 Under physician's care?	<input type="checkbox"/>	34 Asthma?	<input type="checkbox"/>
Details:		35 Sleep Apnea?	<input type="checkbox"/>
9 Hospitalization/operation(s) in last 5 years?	<input type="checkbox"/>	36 Tuberculosis?	<input type="checkbox"/>
Details:		37 Sinus trouble?	<input type="checkbox"/>
10 Head/neck/mouth injuries?	<input type="checkbox"/>	38 Cancer?	<input type="checkbox"/>
11 Women: pregnant?	<input type="checkbox"/>	39 Radiation Treatment to Head/Neck?	<input type="checkbox"/>
12 Women: nursing?	<input type="checkbox"/>	40 Chemotherapy?	<input type="checkbox"/>
13 Women: oral contraceptives?	<input type="checkbox"/>	41 Kidney Disease?	<input type="checkbox"/>
14 Heart trouble/disease?	<input type="checkbox"/>	42 Dialysis?	<input type="checkbox"/>
15 Rheumatic fever?	<input type="checkbox"/>	43 Eating Disorder?	<input type="checkbox"/>
16 Past use of Fenphen?	<input type="checkbox"/>	44 Stomach: reflux? ulcer?	<input type="checkbox"/>
17 Heart murmur?	<input type="checkbox"/>	45 Immunological disease?	<input type="checkbox"/>
18 Mitral valve prolapse?	<input type="checkbox"/>	46 Sjogrens Disease?	<input type="checkbox"/>
19 Heart surgery?	<input type="checkbox"/>	47 Fibromyalgia?	<input type="checkbox"/>
20 Artificial heart valves?	<input type="checkbox"/>	48 Other autoimmune disease (lupus, pemphilus)?	<input type="checkbox"/>
21 Pacemaker?	<input type="checkbox"/>	49 Arthritis or other joint disorders?	<input type="checkbox"/>
22 Indwelling defibrillator?	<input type="checkbox"/>	50 Diabetes? Type: _____ Controlled? Y N	<input type="checkbox"/>
23 Artificial joints?	<input type="checkbox"/>	51 Headaches?	<input type="checkbox"/>
24 History of Organ Transplant?	<input type="checkbox"/>	52 Depression: Diagnosed?	<input type="checkbox"/>
25 High blood pressure? BP: /	<input type="checkbox"/>	53 Other Psychiatric Disorders?	<input type="checkbox"/>
26 Stroke?	<input type="checkbox"/>	54 Neurologic Disease?	<input type="checkbox"/>
27 Bleeding problem?	<input type="checkbox"/>	55 Convulsions?	<input type="checkbox"/>
28 Hemophilia?	<input type="checkbox"/>	56 Epilepsy/seizures?	<input type="checkbox"/>
29 Anemia?	<input type="checkbox"/>	57 Cerebral Palsy?	<input type="checkbox"/>
30 Leukemia?	<input type="checkbox"/>	58 Fainting/dizziness?	<input type="checkbox"/>
31 Lung disease?	<input type="checkbox"/>	59 Venereal disease?	<input type="checkbox"/>
32 Emphysema?	<input type="checkbox"/>	60 AIDS/HIV positive?	<input type="checkbox"/>
33 Shortness of Breath?	<input type="checkbox"/>	61 Alcohol or chemical dependency?	<input type="checkbox"/>
		62 Hepatitis?	<input type="checkbox"/>
		63 Thyroid disease?	<input type="checkbox"/>
		64 Glaucoma?	<input type="checkbox"/>

**TOBACCO**

65 Tobacco user?	Yes	<input type="checkbox"/>
Type:		
Amount:		
Number of years:		
66 How soon after wake up do you use tobacco? <div style="text-align: center;">&lt;30 minutes    &gt;30 minutes</div>		
67 Previous attempts to quit?		<input type="checkbox"/>
Number of attempts:		
Longer period of success:		
Methods used:		
68 Are you interested in quitting tobacco?		<input type="checkbox"/>
69 Former tobacco user?		<input type="checkbox"/>
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	<input type="checkbox"/>
81 Primary source of drinking water? (circle)		
City water filtered      City water unfiltered		
Bottled water              Well water		

**PAST DENTAL TREATMENT:**

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

**DO YOU HAVE CONSISTENT PROBLEMS WITH:**

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

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: \_\_\_\_\_