SMILES IN GAINESVILLE

Thank you for joining our Family!

PATIENT INFORMATION:

Last Name: _____ First Name: _____Middle Initial: _____ Married:Y/N

Gender: M/F Date of Birth: _____ SSN: _____Driver's License: _____

Street Address: _____City:_____Zip_____

Email: _____Home Phone: _____Cell Phone:_____

Emergency Contact: _____ Phone: _____

How Did you hear about us: _____

RESPONSIBLE PARTY

If the patient is under 18 yrs old, please complete the following:

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ Gender: M/F Married Y/N SSN: _____Driver's' License: _____

Email Address: _____Home Phone: _____Cell Phone: _____

INSURANCE POLICY

Patient relationship to Subscriber [} Self [ ] Spouse [ ] Child

Subscriber Name: _____ Subscriber ID# _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group#: _____

FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance and receive payment directly from them. If sent to collections, I agree to pay all related fees and court cost. Every effort will be made to help with my insurance, but if they do not pay as expected, I will still be responsible. Treatment plans may change and you will be responsible for the work actually done. We do our best to give you accurate representation of what they should pay. I understand that all fees are payable at the time of treatment.

Signature: _____ Date: _____

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MEDICAL HISTORY

Name of Medical Doctor_____ City/St_____ Last visit_____

List of Current Medications & Dosages **Are you allergic to any medications**

Please list reason for taking each medication

[ ] None

_____

_____

_____

_____

_____

[ ] None
[ ] Aspirin
[ ] Codeine
[ ] Penicillin
[ ] Erythromycin
[ ] Other: _____

[ ] Local Anesthetic
[ ] Metals
[ ] Other Narcotics
[ ] Sulfa Drugs
[ ] Latex

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Artificial Heart Valve
[ ] Asthma/Hay Fever
[ ] Blood Clotting Issues
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor
[ ] Cardiac Pacemaker
[ ] High Blood Pressure
[ ] HPV
[ ] Diabetes *(if yes, most recent A1C: _____)*
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequent Dry Mouth
[ ] Gallbladder Issues
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] Hives/Skin Rash
[ ] Snoring/Sleep Disorder
[ ] Sleep apnea -- CPAP [ ]
[ ] Joint Replacement *joint_____/yr_____*
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] STD
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Disorders
[ ] Tuberculosis
[ ] Other:_____

Do you Premedicate? Y/N If so, for what reason and date started _____

*Are you taking any form of blood thinners or aspirin? Y/N Name/dosage of medication_____

*Are you taking or have you taken bisphosphonates (e.g. Fosamax) for osteoporosis? Y/N

*Tobacco Use: Y/N If so, what kind and how often?_____

**Women:* Are you pregnant? Y/N Are you using any form of birth control? Y/N

*Reason for today's visit: _____

*Are you in pain? Y/N *Date of Last Dental Visit: _____

*Do your gums bleed: Y/N *History of TMJ issues/Teeth Grinding: Y/N

*Do you like to have nitrous oxide? Y/N

*Unusual reaction to dental injections in the past? Y/N

*How happy are you with your smile? *Not happy* 1 2 3 4 5 6 7 8 9 10 *Very happy*

Pharmacy of choice:_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Signature:_____ Date:_____

SMILES

IN GAINESVILLE

Acknowledgement of Receipt of Notice of Privacy Practices Consent to Use and Disclose Protected Health Information.

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the LIMITED use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing the consent. By signing Below, you Acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purpose of Treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal Privacy Standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on with your revocation of consent is received will NOT be affected.

Printed Name: _____

Signature: _____

Date: _____

I Authorize Smiles In Gainesville to discuss and/or release my medical/dental information including lab and test results, diagnosis, and treatments discussed to the following persons. Also, I authorize to discuss my account information including account balances, insurance, statements, and payment options to the same persons.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____Date:_____

Witness Signature: _____Date:_____

SMILES

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CONSENT TO PROCEED

I authorize Dr. Shaw and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s) including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that in a rare situation, needles break and may require surgical retrieval. In the rare situation, drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleaning and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications, although rare, may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Patient Signature: _____Date Signed: _____

SMILES

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Social Media Informed Consent

Smiles In Gainesville is pleased to participate in social media outlets. Through these venues, we share office updates, new contests, and other fun and helpful information. With the expressed permission of our patients, we are pleased to also share posts of before and after completing their treatment and posting photos of our patient's beautiful new smiles. (Photos will not be full face)

☐ I give my consent to allow Smiles In Gainesville to post updates or photographs of me/my child on social media.

☐ I do not give my consent to me/my child's information/photo being shared on social media.

Name of Patient: _____ Date: _____

Signature of Patient or Responsible Party: _____