SMILE SOLUTIONS

WILLIE CANTU D.D.S

New Patient Information

For your welfare and our efficiency of diagnosis, treatment and billing, please fill out this confidential form completely. Please answer ALL questions. If a question does not apply, please mark N/A in the blank. Thank you.

Patient Information:

Date: _____

❍ Mr. ❍ Mrs. ❍ Miss ❍ Dr. First Name: _____ Last Name: _____

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Widowed ❍ Legally Separated Gender: ❍ Male ❍ Female

Date of Birth: _____ Age: ____ SSN: _____ Email: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Cell #: _____ Have you ever been a patient of our practice? ❍ Yes ❍ No

Driver's License #: _____

Employer: _____ Work #: _____

Student: ❍ Yes ❍ No ❍ FT ❍ PT School Name/Address: _____

Physician: _____ Phone #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Who will be responsible for your account? ❍ Self ❍ Spouse ❍ Father ❍ Mother ❍ Other: _____

(If self, skip to next section)

Name: _____ SSN: _____ Date of Birth: _____ Age: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Employer: _____ Work #: _____

Spouse Information

Name: _____ SSN: _____ Birth Date: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Employer: _____ Work #: _____

Dental Insurance Information: Primary

Policy Holder: _____ DOB: _____ Relationship to Patient: _____

Insurance Co. Name & Address: _____

Phone #: _____ Subscriber #: _____ Group #: _____

Who may we thank for referring you? _____

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Patient Health History

Patient:_____

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ..... **Y N**

   Height _____ Weight _____

2. Has there been any change in your general health in the past year? ..... **Y N**

3. Date of last Physical exam? _____

4. Are you currently under a physicians care for a particular problem? ..... **Y N**

5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe ..... **Y N**

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**

   A. Rheumatic Fever or Rheumatic Heart Disease? ..... **Y N**
   B. Congenital Heart Disease? ..... **Y N**
   C. Cardiovascular Disease (Heart attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker? ..... **Y N**
   D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... **Y N**
   E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... **Y N**
   F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... **Y N**
   G. Liver Disease (Jaundice, Hepatitis)? ..... **Y N**
   H. Kidney Disease? ..... **Y N**
   I. Diabetes? ..... **Y N**
   J. Thyroid Disease? ..... **Y N**
   K. Arthritis? ..... **Y N**
   L. Stomach Ulcers or Colitis? ..... **Y N**
   M. Glaucoma? ..... **Y N**
   N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... **Y N**
   O. Treatment for Cancer (Radiation or Chemo)? ..... **Y N**
   P. Clicking/popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... **Y N**
   Q. Sinus or Nasal Problems, Snoring or Sleep Apnea? ..... **Y N**
   R. Any disease, drug, or transplant operation that has depressed your immune system? ..... **Y N**

7. **ARE YOU USING ANY OF THE FOLLOWING?**

   A. Antibiotics? ..... **Y N**
   B. Anticoagulants? ..... **Y N**

All responses are confidential.

   C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... **Y N**
   D. High Blood Pressure Medications? ..... **Y N**
   E. Steroids (Cortisone, etc.)? ..... **Y N**
   F. Tranquilizers? ..... **Y N**
   G. Insulin or Oral Anti-Diabetic Drugs? ..... **Y N**
   H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... **Y N**
   I. Are you taking, or have you ever taken Bisphosphanates (Fosamax, Zometa, Actonel, Bondronat, Aredia, Didronel, Bonefos, Loron, Skelid, neridronate, olpadronate) for osteoporosis ..... **Y N**

* Please list **any and all** medications taken, including prescription and over-the-counter medications, herbal or holistic remedies, vitamins and minerals.

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

   A. Local Anesthesia? ..... **Y N**
   B. Penicillin or other antibiotics? ..... **Y N**
   C. Sedatives, Barbiturates? ..... **Y N**
   D. Tranquilizers? ..... **Y N**
   E. Aspirin or Ibuprofen? ..... **Y N**
   F. Latex or Rubber Products? ..... **Y N**
   G. Other allergies or reactions? Please list ..... **Y N**

_____

_____

9. Do you smoke or chew tobacco? ..... **Y N**

   How much per day? _____ Number of years? _____

10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ... **Y N**
11. Have you had any serious problems associated with any previous dental treatment? ..... **Y N**
12. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... **Y N**
13. **FOR WOMEN ONLY**

    A. Are you pregnant, or is there any chance you might be pregnant? ..... **Y N**
    B. Are you nursing? ..... **Y N**

* Please be aware that antibiotics can reduce the effectiveness of oral contraceptives. A backup method is highly recommended.

Please give details to any positive responses to the above questions

_____ Signature of Patient or Guardian

_____ Date

_____ Doctor's Initials

Receipt of Notice of Privacy Practices

Smile Solutions
Willie Cantu, DDS

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Smile Solutions Financial Agreement

- **Financial Agreement For Our Patients Without Dental Insurance**

☐ Payment is expected at time of service, unless prior arrangements have been made.

- **Financial Agreement For Our Patients With Dental Insurance**

Our office will file your insurance claim for you. This is a special service we provide for our patients to help eliminate some of the often-confusing paperwork associated with processing claim forms.

For Our Patients With Insurance,
Please Select One Of The Following Options:

☐ Option 1

Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. If you prefer we wait for payment from your insurance company, we require a credit card with authorization to transfer any balance left unpaid by your insurance company 30 days after the date of service.

Cardholders Name_____

o Visa o Master Card o Discover o American Express

Account #_____

Signature_____ Exp. Date_____

o If you would like to be contacted prior to running credit card, please provide us With a Good contact number:_____

☐ Option 2

You choose to pay your balance in full on the date of service. We will submit your insurance claim for you with directions to send the reimbursement directly to you.

I have read Smile Solutions Financial Agreement and have selected my form of payment.

_____
Patient or Guardian Signature