Welcomes You!

Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)
Gender: _____Birth Date:________________ Age:____Email:____
Phone (Cell): ______________________ (other):____________________________Can we text you?:______
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S ☐S
Address: ____
Street Apartment #
____
City State Zip Code

Health Information

Date of last physician (medical Doctor) visit: ________ MD Name:____________________ PH:__________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy/seizures

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems

☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Thyroid Problem
☐ Joint Replacement or Pins/plates in bone
☐ Breast augmentation

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Emergency Contact:____________________________________ Phone:__________________
- Do you have any health problems that need further explanation? ☐ Yes ☐ No
  If yes, please explain: ____

Medications:____

____

Allergies (including prescription drugs):____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the hygienist at the next appointment without fail.

____ Date: __________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to Healthy Smiles Shine? ___________________________________

Spouse or Responsible Party Information

The following is for: the person responsible for payment--if

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Birth Date: ____

Phone (Cell): ________________ (Work): ________________ Ext: ______ Best time to call: ______________

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name:____________________________________ Phone:___________________

Address:____

About You

(We want to get to know you!)

Occupation (or school if student):____

Hobbies/interests:____

Favorite Food:____

Something unique about you:____

Dental History

Name of Dentist (current or former)___________________________________ Date of last visit:____________

Reason for today's visit:_____________________________ Current toothbrush: manual sonic spin

Do you like your smile?________ Have you ever used or interested in any whitening products?______________

Please circle:

Do your gums bleed while brushing or flossing? Yes No

Do you have any lumps or sores in or near your mouth? Yes No

Are your teeth sensitive to hot/cold? Yes No

Do you grind or clench your teeth? Yes No

Do you have frequent headaches? Yes No

Do you have dentures or partial dentures? Yes No

Do you feel pain in your mouth or teeth? Yes No

Do you have jaw pain? Yes No

Are your teeth sensitive to sweet? Yes No

Do you wear a night guard or retainer? Yes No

Do you have any dental implants? Yes No

Are you worried that you have bad breath? Yes No

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
In consideration for the professional services rendered to me, or at my request, by the Hygienist, I agree to pay therefore the reasonable value of said services to said Hygienist, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney or collection agency (up to 35%) fees if suit be instituted hereunder.
I grant my permission to said Hygienist or a Healthy Smiles Shine representative, to telephone me at home or at my work to discuss matters related to this form.
I understand that I am being seen by a licensed Colorado Dental Hygienist. I understand that is recommended that I see a licensed Colorado Dentist for dental exams yearly and that I am responsible for obtaining those exams.

___ At this time, I do not want Healthy Smiles Shine LLC to share my dental information with any dental office.

OR,

___ I give permission for Healthy Smiles Shine LLC to share necessary information with: (please list individual or Dentist)
Name: ____ Phone:____________________

OR,

___ I would like Healthy Smiles Shine LLC to share my information with a recommended dentist/specialist.

I understand that my information, when shared, will be done via email and that it may not be encrypted.

I have read the above conditions of treatment and payment and I agree to their content.

____ Date: ____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

____ Date: ______________ Relationship to Patient: ____________________
Signature of guarantor of payment/responsible party