VITALSMILES
DENTAL & ORTHODONTICS

Patient Name _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed

Birthdate _____ Age _____ Social Security# _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

(_____)_____ (_____)_____ _____
Home/Cell Phone Work Phone Email Address

In the event of an emergency who should we contact?

Name _____ Relationship _____

(_____)_____ (_____)_____
Home/Cell Phone Work Phone

**Dental Insurance Information:**

| | **Primary Insurance** | | **Secondary Insurance** |
|---|---|---|---|
| Name of Insured: | _____ | Name of Insured: | _____ |
| Relationship to Patient: | _____ | Relationship to Patient: | _____ |
| Insured Birth Date: | _____ | Insured Birth Date: | _____ |
| Insured SSN#: | _____ | Insured SSN#: | _____ |
| Employer: | _____ | Employer: | _____ |
| Insurance Company: | _____ | Insurance Company: | _____ |
| Insurance ID# | _____Group#:_____ | Insurance ID# | _____Group#:_____ |
| Insurance Co. Address: | _____ | Insurance Co. Address: | _____ |
| | _____ | | _____ |
| Insurance Co. Phone: | _____ | Insurance Co. Phone: | _____ |

**Dental History:**

Date of last dental visit _____Reason for today's visit_____

Do you have any of the following problems? Please check those that apply:

☐ Pain with a tooth
☐ Pain when biting
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sores/growths in mouth
☐ Clicking or Popping Jaw
☐ Unpleasant taste/Bad Breath
☐ Clenching/Grinding your teeth
☐ Gum problems/Bleeding gums
☐ Lip or Cheek Biting
☐ Other

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**Medical History:**

Physician's Name_____ Phone _____

List any medications you are currently taking below. (Prescription & non-prescription) Additional paper available if needed.

| Name of Medication | Dosage/ Frequency | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had any of the following? (Check all that apply):

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve•
- ☐ Artificial Joint/Pins*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Attack/ Failure
- ☐ Heart Murmur*
- ☐ Heart Pacemaker*
- ☐ Heart Trouble / Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse•
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever•
- ☐ Rheumatism
- ☐ Scarlet Fever•
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Other_____

Do you use tobacco?_____ Do you use smokeless tobacco? _____ Do you use controlled substances? _____

**Women:·** Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:** (Check all that apply):

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal Penicillin ☐ Sulfa ☐ Other

Have you ever been treated in the emergency room? ☐ Yes ☐ No

IF "YES", PLEASE LIST DATE(S) AND EXPLAIN:_____

Have you ever been hospitalized? Yes No

IF "YES", PLEASE LIST DATE(S) AND EXPLAIN:_____

Have you ever had any surgeries? Yes No

IF "YES", PLEASE LIST DATE(S) AND EXPLAIN:_____

I certify that I have read and understand the above. I acknowledge that all my questions have been answered to my satisfaction. I certify that al) of my answers to the preceding questions are true. I will not hold the dentist or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I also understand that while I may have insurance benefits, I am ultimately responsible for any balances not paid by my insurance company.

_____

PARENT/GUARDIAN SIGNATURE DATE

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 arid will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict bow private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE _____ SIGNATURE _____

## VITAL SMILES ALABAMA, PC
## POLICY REGARDING APPOINTMENTS

Vital Smiles is here to serve children that have Medicaid, Blue Cross and other federally subsidized insurance plans. Because of the great demand for these services, our time is very valuable, and we have found it necessary to implement some policies regarding our appointment times. If the parent or legal guardian of the patient does not call or reschedule an appointment at least 24-hours ahead of time it will count as a BROKEN APPOINTMENT. After three (3) NO SHOWS or BROKEN APPOINTMENTS you will lose your appointment privileges. Your child may be seen as a walk-in. You may come to the office between 8:00am-8:30am or l:00pm-1:30pm. We will work your child into the schedule. Thank you for helping us serve all our patients in a timely manner.

I understand and agree to the policies explained to me in the above statement.

SIGNATURE _____ DATE _____

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## FOR OFFICE USE ONLY

**I have reviewed the patient information form and did not find any discrepancies.**

FRONT DESK INITIALS _____ HYGIENIST INITIALS _____ DENTIST INITIALS _____ DATE _____