Welcome to Smile Boutique

Tell Us About Yourself

Date: _____ **Email**:_____

Name:_____ _____ **Preferred Name**:_____

Last **First** **MI** **Mr. Mrs. Ms. Dr.**

Birth Date:___/____/_____ **Age**:___ **Social Security Number**:_____-_____-_____ **Marital Status**: S M D W

Home Address:_____

Street **City** **State** **Zip**

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)___-____ Ext:_____

DL#:_____

When & where are the best times to reach you? _____

Other family members seen by us:_____

Whom may we thank for referring you to our office? _____

Employer:_____**Occupation**:_____

Address:_____

Street/PO Box **City** **State** **Zip**

Neighbor or Relative Not Living With You

His/Her Name:_____ Relation:_____ Phone: (_____)_____-_____

Spouse Information

His/Her Name:_____ Birth Date:_____/_____/_____ Social Security:_____-_____-_____

Employer:_____ Work Phone: (_____)_____-_____Ext:_____ DL#:_____

Person Responsible for Account if Other Than Yourself

Name:_____ Relation:_____ Phone: (_____)_____-_____

Birth Date: _____/_____/_____ Social Security Number:_____-_____-_____

Employer:_____ Work Phone: (___)___-____ Ext.:_____ DL#:_____

Billing Address:_____

Street **City** **State** **Zip**

Insurance Information

Primary Insurance: Dental Y/N Medical Y/N

Insurance Name:_____ Phone: (____)____-_____ Group#:(Plan/Policy)_____

Insurance Address:_____

Street/ PO Box **City** **State** **Zip**

Insured's Name:_____ Social Security Number:____-____-_____ BirthDate:___/__/___ Relation:_____

Insured's Employer:_____Address:_____

Street/PO Box **City** **State** **Zip**

Secondary Insurance: Dental Y/N Medical Y/N

Insurance Name:_____ Phone: (____)____-_____ Group #:(Plan/Policy)_____

Insurance Address:_____

Street/ PO Box **City** **State** **Zip**

Insured's Name:_____ Social Security Number:____-____-_____ BirthDate:___/___/___ Relation:_____

Insured's Employer:_____Address:_____

Street/PO Box **City** **State** **ZiP**

Authorization & Release

I authorize the dentist(s) to release information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

_____

Signature of Patient, Guardian, or Personal Representative Date

_____

Please print name of Patient, Guardian, or Personal Representative Date

DENTAL HISTORY

PATIENT NAME _____ Birth Date _____
What is the reason for your visit today?_____
Former Dentist? City & State?_____
Date of last dental cleaning?_____ Date of last X-Rays:_____

Please check any of the following that apply:

O Bad Breath	O Bleeding Gums	O Blisters on lips/mouth	O Burning sensation on tongue
O Chew on one side of mouth	O Clicking or popping jaw	O Dry mouth	O Fingernail biting
O Foreign objects	O Grinding/Clenching teeth	O Gums swollen or tender	O Jaw pain or tiredness
O Lip or cheek biting	O Loose teeth	O Broken fillings	O Mouth breathing
O Mouth pain, brushing	O Orthodontic Treatment	O Pain in/around ear	O Periodontal treatment
O Sensitivity to cold	O Sensitivity to hot	O Sensitivity to sweets	O Sensitivity to chewing
O Sores or growths in mouth	O Food collection between teeth		O Pain in jaw joints

How often to you floss?_____ How often do you brush?_____
Do you still have your wisdom teeth? If yes, why?
_____
Do you require pre-medication before dental treatment
_____
Are you happy with your smile?_____ If not, what would you like to change?_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.
Are you under a physician's care now? O Yes O No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:_____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:_____
Are you taking any over the counter or prescription medications? O Yes O No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No
Are you on a special diet? O Yes O No
Do you use tobacco? O Yes O No
Do you use controlled substances? O Yes O No

WOMEN: Are you Pregnant/ Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

O Aspirin	O Penicillin	O Codeine	O Local Anesthetics	O Acrylic	O Metal
O Latex	O Sulfa drugs	O Other If yes, please explain:_____			

Do you have, or have you had, any of the following? Check ALL that may apply to you.

O ADD/ADHD	O Diabetes	O Hives or Rash	O Sinus Trouble
O AIDS/HIV Positive	O Drug Addiction	O Hypoglycemia	O Spina Bifida
O Anaphylaxis	O Emphysema	O Irregular Heartbeat	O Stomach Disease
O Anemia	O Epilepsy or Seizures	O Kidney Problems	O Stroke
O Angina	O Excessive Bleeding	O Leukemia	O Swelling of Limbs
O Arthritis/Gout	O Excessive Thirst	O Liver Disease	O Thyroid Disease
O Artificial Heart Valve	O Fainting Spells/Dizziness	O Low Blood Pressure	O Tonsillitis
O Artificial Joints	O Frequent Headaches	O Lung Disease	O Tuberculosis
O Asthma	O Hay Fever	O Mitral Valve Prolapse	O Tumors/Growths
O Autism	O Heart Attack/Failure	O Osteoporosis	O Ulcers
O Blood Disease	O Heart Murmur	O Parathyroid Disease	
O Blood Transfusion	O Heart Pacemaker	O Psychiatric Illness/Disorder	
O Bruise Easily	O Heart Surgery	O RadiationTreatment	
O Cancer	O Hemophilia	O Recent Weight Loss	
O Chemotherapy	O Hepatitis A	O Rheumatic Fever	
O Chest Pains	O Hepatitis B or C	O Rheumatism	
O Cold Sores/Fever Blisters	O Herpes	O Scarlet Fever	
O Congenital Heart Disorder	O High Blood Pressure	O Shingles	
O Cortisone Medicine	O High Cholesterol	O Sickle Cell Disease	

Have you ever had any serious illness not listed above? O Yes O No
If yes, please explain:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Policy Page

We want to welcome you to our dental office. Below is a summary of our office policies which we hope will provide you with the information necessary to make informed decisions about you and your family's oral care.

Appointments:

- Call the Smile Boutique at 817-725-8222. 24 hours prior to an appointment If the appointment is not going to be utilized/if the visit is being cancelled or postponed.
- We reserve the right to charge $25 for no show appointments **without** 24 hour cancellation notice.
- Please be aware patients that arrive more than 10 minutes late for their appointments may be asked to reschedule.

Payments:

- We collect all co-pays, deductibles, and co-insurance at the time of service. This is according to the benefit quote that our office obtains from your insurance company.
- We have a $30.00 fee for all return checks.

Holidays:

- The office is closed for all major holidays. For urgent and emergency care, patients are to call our office line to receive an after hours line.

Inclement Weather:

- For inclement weather office hours, please check our website at www.smileboutiquedfw.com. For urgent and emergency care when the office is closed due to inclement weather, please use the URGENT CARE and EMERGENCY CARE guidelines previously listed

I have read and understood the policies of Smile Boutique and agree to all the terms described in it.

_____ _____

Parent Signature/Guardian Signature Date

Smile Boutique Dental Care

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
****You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Acts.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_____
For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

_____
_____
_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacies that are described in this Notice while it is in effect. This Notice takes effect 4/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of Notice for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information list at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to obtain payment for service we provide to you.

Payment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorizations: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorizations to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family & Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your health information to notify or assist in the notification or (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with and opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclosehealth information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick p filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Service: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required by law to do so.

Abuse or Neglect: We may disclose your health information to appropriate authorities If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may also disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.