Welcome to Smile with Style!

The benefits of a happy and healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out these forms completely. The better we communicate, the better we can care for you!

3261 N. Harbor Blvd. Suite A • Fullerton, CA 92835 • 714.870.9445 • www.SmileWithStyle.com

1. Patient Information

Date: _____

Name: ❍Mr. ❍Mrs. ❍Ms. ❍Dr.

_____
Last First MI

I prefer to be called: _____ Sex: ❍Male ❍Female

Status: ❍Married ❍Single ❍Divorced ❍Widowed ❍Domestic Partner

Birthdate: _____/_____/_____

Social Security #: _____-_____-_____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____)_____

Home Phone: (_____)_____

Work Phone: (_____)_____ ext: _____

Occupation: _____ ❍FT or ❍PT

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

2. Spouse's Information

Name: _____

Birthdate: _____/_____/_____

Social Security #: _____-_____-_____

Cell Phone: (_____)_____

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (_____)_____ ext: _____

3. Miscellaneous Information

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

_____

Relationship: _____ OR

Internet: ❍Google ❍Yelp ❍Next Door ❍Other: _____

Person to contact in the event of an emergency: _____

_____

Relationship: _____

Phone: (_____)_____

4. Dental Insurance #1

Insured's Name: _____

Insured's Birthdate: _____/_____/_____

Insured's Social Security #: _____-_____-_____

Insured's Employer: _____

Ins. Company: _____

Ins. Co. Phone: (_____)_____ ext: _____

Ins. Address: _____

City: _____ State: _____ Zip: _____

Ins. ID No. _____

Ins. Group No. _____

5. Dental Insurance #2

Insured's Name: _____

Insured's Birthdate: _____/_____/_____

Insured's Social Security #: _____-_____-_____

Insured's Employer: _____

Ins. Company: _____

Ins. Co. Phone: (_____)_____ ext: _____

Ins. Address: _____

City: _____ State: _____ Zip: _____

Ins. ID No. _____

Ins. Group No. _____

6. Medical History

Are you currently under the care of a physician? Y / N

Please explain: _____

_____

_____

Physician's Name: _____

Work Phone: (_____)_____

Date of last visit to physician: _____/_____
mo year

Your current physical health is: ❍Good ❍Fair ❍Poor

Are you taking any medication, drugs or pills? Y / N

Please list each one: _____

_____

_____

_____

6. Medical History Continued...

Have you ever had any of the following? Please circle your answer for each line:

Y / N Angina Pectoris
Y / N Anemia/Radiation Treatment
Y / N Artificial Bones/Joints/Valves
Y / N Arthritis
Y / N Asthma
Y / N Bisphosphonate Use
Y / N Blood Transfusion
Y / N Cancer/Chemotherapy
Y / N Congenital Heart Defect
Y / N Diabetes
Y / N Difficulty Breathing
Y / N Drug/Alcohol Abuse
Y / N Emphysema
Y / N Fainting/Dizzy Spells
Y / N Fever Blisters/Herpes
Y / N Glaucoma
Y / N Heart Attack/Stroke
Y / N Heart Murmur
Y / N Heart Surgery
Y / N Hemophilia/Abnormal Bleeding
Y / N Hepatitis
Y / N High/Low Blood Pressure
Y / N HIV/AIDS
Y / N Hospitalized for Any Reason
Y / N Kidney Problems
Y / N Mitral Valve Prolapse
Y / N Nervousness
Y / N Pacemaker
Y / N Psychiatric Problems
Y / N Rheumatic/Scarlet Fever
Y / N Shingles
Y / N Sinus Problems
Y / N Thyroid Problems
Y / N Tuberculosis (TB)
Y / N Ulcers/Colitis
Y / N Venereal Disease

Please list any other serious medical condition(s) that you have had: _____

_____

Has a physician ever informed you that you needed pre-medication with an antibiotic prior to dental treatment? Y / N

Are you allergic to any of the following?

Y / N Aspirin, Ibuprofen, Tylenol
Y / N Codeine
Y / N Dental Anesthetics
Y / N Erythromycin
Y / N Latex
Y / N Penicillin
Y / N Tetracycline
Y / N Metals, Fluoride, etc.

Please list any other drugs or substances that you have reacted adversely to: _____

_____

_____

Do you smoke: Y / N

7. For Woman Only

Y / N Are you taking birth control pills?
Y / N Are you pregnant?
Y / N Are you nursing?

8. Dental History

Why have you come to Smile with Style today? _____

_____

_____

Previous Dentist Name: _____
Phone: (_____)_____
Date of last dental visit: _____/_____ (mo / year)
Date of last dental x-rays: _____/_____ (mo / year)

Reason for leaving previous dental office: _____

_____

- Are you currently in pain? Y / N
- Have you ever had a serious/difficult problem associated with any previous dental work? Y / N
- Have you ever had gum treatment? Y / N
- Have you ever had TMJ problems *(jaw joint)*? Y / N
- Would you like to change your mercury fillings to white? Y / N
- Would you like to have whiter teeth? Y / N
- Do you grind or clench your teeth? Y / N
- Do you get headaches? Y / N
- Do you get migraines? Y / N
- Do your gums bleed when you brush? Y / N
- Do you snore? Y / N
- Do you have sleep apnea? Y / N
- Your current dental health is: ❍Good ❍Fair ❍Poor
- How many times a week do you floss *(be honest ☺)*? _____
- How many times a day do you brush? _____
- Type of bristle? ❍Soft ❍Medium ❍Hard
- Would you like whiter teeth? Y / N
- Would you like straighter teeth? Y / N
- Are your teeth sensitive to hot, cold or anything else? _____

_____

_____

All medical history information will be kept confidential. I understand that the information I have given today is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status or if I start a new medication.

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Blood Pressure: _____
Pulse Rate: _____/ minute
Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I verbally reviewed the medical/dental information above with the patient named herein.

Initials/Date	Initials/Date	Initials/Date	Initials/Date
_____/_____	_____/_____	_____/_____	_____/_____
_____/_____	_____/_____	_____/_____	_____/_____
_____/_____	_____/_____	_____/_____	_____/_____
_____/_____	_____/_____	_____/_____	_____/_____

CONSENT

TREATMENT

*I authorize **Kirk Larson, D.D.S., Timothy Hedrick, D.D.S. and staff** to take x-rays, study models, photographs, 3D scans or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs. I further authorize the doctors and staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.*

I acknowledge that the dentist may engage the assistance of other specialists in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentisty is not an exact science and that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

PATIENT CONSENT

*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 and will be used to:*

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

*I have been informed by you of 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 office at any time to obtain the most current information.*

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

FINANCIAL

I acknowledge that I am responsible for the payment of all fees associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not party to this contract and the services, treatments, procedures and/or diagnostic methods provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me.

FINANCIAL (continued)

As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable to any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or any changes thereto.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance due to me for the servies, treatments, procedures and/or diagnostic methods provided to me, and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist or any agent of the dental office or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred (a) by mail at any address that I provide to the dental office and/or (b) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

I agree to promptly pay all amounts due and I understand that all returned checks will be subject to a $15 return check fee.

DELINQUENCY, ACCOUNTS, COLLECTION

Any account balances that remain unpaid for 90 days from the date of service may be referred to a collection company or an attorney. In the event this occurs, I understand that I will be liable for collection costs. Additionally, in the event any unpaid account balance is referred to an attorney for collection by the dentist or a collection agency, I agree to be responsible for all costs and reasonable attorneys' fees incurred in connection therewith.

FAILED APPOINTMENTS

*I agree to give the office at least 2 business days notice if I am unable to keep my appointment. **I agree that after 2 FAILED appointments, I will PREPAY for future visits.***

PHOTOGRAPHS, VIDEOS, IMAGES

I acknowledge that photographs, videos, and other images, such as x-rays, 3D scans and other records may be created during my examination, treatment, and follow-up care. By signing below, I give my permission for such items to be used for purposes of reasearch, education, advertisement or publication. Identifying information will be omitted. I also understand that I have a right to refuse to sign this acknowledgement.

Patient Name: _____ **Relationship to Patient (if other than self):** _____

Responsible Party Signature: _____ **Date:** _____