

smile DENTISTRY

with Dr. Renee Blondo

Date: _____ Name: _____
Date of Birth: _____ Sex (circle) M or F Weight: _____ Height: _____
Home Address: _____ City: _____ Zip: _____
Social Security Number (insurance purposes): _____
Parent / Guardian's name: _____
Home Phone: _____ Cell: _____
Email Address: _____

Insurance:

Dental Insurance Company: _____
Policy Holder's Name: _____ Employer/Occupation: _____
Policy Holder's Social Security Number: _____ Date of Birth: _____

Dental Health:

Reason for your visit: _____

When was your last dental visit? _____

Are you apprehensive (nervous) about your dental treatment? ☐ Yes ☐ No

If yes- have you ever had: ☐ Nitrous Oxide ☐ Medication prior to treatment

Have you ever had any serious problems with previous dental treatment? ☐ Yes ☐ No

If yes, explain: _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you routinely use mouth rinse? ☐ Yes ☐ No How often? _____

What texture brush do you use? _____ ☐ Soft ☐ Medium ☐ Hard

Do you gag easily? ☐ Yes ☐ No

Do your gums bleed while brushing and/or flossing? ☐ Yes ☐ No

Are you experiencing any pain or sensitivity? ☐ Yes ☐ No

Are any of your teeth sensitive to air or during chewing? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No

Do you clench or grind your teeth while sleeping or during the day? ☐ Yes ☐ No

Have you had any dental x-rays in the last five years? ☐ Yes ☐ No

Please add anything you feel is important: _____

Medical Health:

General Health (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your Physician: _____

Are you presently under the care of a physician? ☐ Yes ☐ No

If yes, explain why? _____

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic to: ☐ Antibiotics ☐ Codeine ☐ Aspirin ☐ Local Anesthetics

Any other medications? _____

Have you ever been hospitalized? If so, list reasons & dates.

Have you had any blood transfusions? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you have a history of cold sores, fever blister, or canker sores? ☐ Yes ☐ No

Are you being treated with immunosuppressive drugs? ☐ Yes ☐ No

Please Check All That Apply:

- | | | | | | |
|--|---|---|---|--|---|
| ☐ Allergies | ☐ Anemia | ☐ Artificial Heart Valve | ☐ Asthma | ☐ Blood Disease | ☐ Breathing Problems |
| ☐ Bruise Easily | ☐ Cancer | ☐ Chemotherapy | ☐ Convulsions | ☐ Diabetes | ☐ Eating Disorder |
| ☐ Epilepsy/Seizures | ☐ Excessive Bleeding | ☐ Excessive Thirst | ☐ Fainting Spells/Dizziness | ☐ Frequent Cough | |
| ☐ Frequent Diarrhea | ☐ Frequent Headaches | ☐ Hemophilia | ☐ Hepatitis A | ☐ Hepatitis B or C | |
| ☐ Irregular Heartbeat | ☐ Kidney Problems | ☐ Liver Disease | ☐ Lung Disease | ☐ Mitral Valve Prolapse | |
| ☐ Osteoporosis | ☐ Pain in Jaw Joints | ☐ Psychiatric Care | ☐ Radiation Treatments | ☐ Renal Dialysis | |
| ☐ Rheumatic Fever | ☐ Rheumatism | ☐ Scarlet Fever | ☐ Shingles | ☐ Sickle Cell Disease | |
| ☐ Sinus Trouble | ☐ Spina Bifida | ☐ Tonsillitis | ☐ Stomach/Intestinal Disease | | |
| ☐ Thyroid Disease | ☐ Tuberculosis | ☐ Tumors or Growths | ☐ Ulcers | | |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes; _____

Consent:

The undersigned hereby authorizes Dr. Renee Biondo to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

Patient Signature (Parent of Child)

Date

Welcome to *smile* DENTISTRY

We are excited you are here and look forward to serving your dental needs. Before we get started, we'd like to review some office policies with you.

Communication:

- We utilize text messaging for confirmations and other office communications. If you cannot or wish not to receive texts from the office, please let us know.
- Our office operates under HIPPA regulations which means we may share your personal health information for purposes of treatment, payment, or health care operations, but will not disclose your information to another individual without your consent. A full copy of our office's Privacy Policy is available upon request.

Financial:

- We are happy to work with your dental insurance to help you maximize your benefits. We cannot however know each individual plan specifics. We try our best to present the most accurate treatment estimates, but sometimes insurances pay out less than expected and it is your responsibility to pay for the difference. Also, if we do not receive payment from your insurance company within 90 days, you will be responsible for the balance on your account and for collecting the benefit from your insurance company.
- We accept payments in the form of cash, check, and credit cards. If needed, we also work with Care Credit to offer interest free financing (subject to credit approval). A \$25 dollar fee will be charged for any returned checks.

Attendance:

- We understand that sometimes appointments need to be rescheduled. We reserve a time slot just for you, so we kindly ask that you give us at least a 24-hour notice if you need to reschedule your appointment.

Compliance:

- A very big part of successful dental treatment is YOU. We strive to do our best, but we cannot do it without your commitment and effort to attain and maintain dental health.

Consent:

- By signing below and continuing with your new patient appointment, you are consenting to allow us to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of your dental needs including x-rays, study models, photographs, medications and the use of local anesthetic agents.
- We utilize dental photography for patient education, record keeping and potentially to showcase our work in lectures, social media posts or in office publications. If your photo is used, we are careful to protect your identity. If you would like to opt out, please let us know.

I, _____, acknowledge that I have read (or that it has been read to me) the above policies. I have been given an opportunity to ask questions and hereby agree to Financial Policy, acknowledge receipt of the Notice of Privacy Practices, and consent to dental treatment and photo release.

Print Patient's Name

Print name of Guardian if applicable

Signature

Date



Missed Appointment & Late Notice Cancellation Policy

When patients fail to show up for their appointments, other patients who need appointments are unable to receive the care they require if we don't have enough notice to fill the empty appointment times. Our policy on late arrivals, cancellations, and no-shows is based on experience and is a critical part of operating our clinic.

PLEASE CONFIRM YOUR APPOINTMENT

We will send out a post card the month of your recall appointment and a text 2 days before your appointment. You MUST reply to the text to confirm your appointment! It's as easy as replying "YES" to the text, which will confirm your appointment.

If you are unable to make your appointment, you can text us back stating you wish to cancel. You can also reschedule or move your appointment to another time by texting. Our staff will respond within minutes, unless outside of business hours, in which case they will respond as soon as the office opens the next business day.

IF YOU DO NOT CONFIRM, SMILE DENTISTRY HAS THE RIGHT TO FILL YOUR ALLOTTED APPOINTMENT TIME

LATE ARRIVALS

Please keep in mind that Smile Dentistry maintains a full schedule. Even one patient running late can impact the schedule of the entire clinic. Please call us if you are running behind so we can manage accordingly.

CANCELLATIONS

If you need to cancel or reschedule your appointment, please give our office at least 24-hour notice so we have time to fill the appointment slot with another patient.

Failure to give a 24-hour notice is considered a missed appointment.

CONSEQUENCES OF MISSED APPOINTMENTS:

- The first missed appointment will be noted in the chart
- The second missed appointment will result in a 30-day delay before you can reschedule
- The third missed appointment will result in you no longer being to be seen by Smile Dentistry

**** ALL MISSED APPOINTMENTS WILL BE CHARGED \$50.00 ****

I, _____, have read and agree to the above Missed Appointment and Late Notice Cancellation Policy.

Signature

Date