Patient Information

Patient Name: _____ (Last) _____ (First) _____ (MI) Preferred Name_____

Social Security Number: _____ Birthdate: _____Gender (circle one): Male Female

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone Numbers: _____ (Home) _____ (Work) _____ (Cell Phone)

E-mail Address: _____

How would you like to be contacted? (circle all) E-Mail Text Call Mail

Emergency Contact or Guardian's name: _____ (Name) _____ (Relationship) _____ (Phone Number)

Whom can we thank for referring you to our practice?

☐ BlissFamily Website ☐ SmileLife Sign ☐ Internet ☐ Insurance

☐ SmileLife Orthodontics ☐ Friend: _____ ☐ Other:_____

Billing Information

Person responsible for this account: (if different than patient) _____ Gender: M F

Driver's License #: _____ Birthdate: _____ Social Security Number: _____

Address: _____ (If different than patient) (Street) (City) (State) (Zip Code)

E-mail Address: (if different than patient) _____

Phone Numbers: (if different than patient)_____ (Home) _____ (Work) _____ (Cell Phone)

Family Status: (circle) Married Single Spouse's Name _____ Spouse's Birthdate:_____

Primary Dental Insurance (Please let us know if you have secondary dental insurance)

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured Birthdate: _____ Insured SSN: _____

Insured Employer Name: _____ Group #: _____

Insurance Plan Name: _____

Insurance Plan Phone: _____ Relationship to Patient: _____

Medical History

Patient Name: _____ Nickname: _____ Age:_____

Name of Physician/and their specialty: _____

Most recent physical examination _____Purpose:_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury	☐	☐
2. An allergic reaction to:		
Aspirin, ibuprofen, acetaminophen	☐	☐
Codeine	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Tetracycline	☐	☐
Sulfa	☐	☐
Local anesthetic	☐	☐
Fluoride	☐	☐
Metals (nickel, gold, silver)	☐	☐
Latex	☐	☐
Other_____	☐	☐
3. Heart problems or cardiac stent within the last 6 months	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Artificial prosthesis (heart valve or joints)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. A stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut (INR >3.5)	☐	☐
13. Emphysema, shortness of breath, sarcoidosis	☐	☐
14. Tuberculosis, measles, chicken pox	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking statin drugs	☐	☐
23. Diabetes (HbA1c=_____)	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive disorders (i.e. celiac disease, gastric reflux)	☐	☐

	YES	NO
26. Osteoporosis (i.e. taking bisphosphonates)	☐	☐
27. Arthritis, rheumatoid arthritis, lupus	☐	☐
28. Glaucoma	☐	☐
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy, convulsions (seizures)	☐	☐
32. Neurologic disorders (ADD/ADHD, prion disease)	☐	☐
33. Viral infections and cold sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Hives, skin rash, hay fever	☐	☐
36. STI/STD	☐	☐
37. Hepatitis (type_____)	☐	☐
38. HIV/AIDS	☐	☐
39. Tumor, abnormal growth	☐	☐
40. Radiation therapy	☐	☐
41. Chemotherapy, immunosuppressive	☐	☐
42. Emotional problems	☐	☐
43. Psychiatric treatment	☐	☐
44. Antidepressant medication	☐	☐
45. Alcohol/street drug use_____	☐	☐
ARE YOU:		
46. Presently being treated for any other illness_____	☐	☐
47. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
48. Often exhausted or fatigued	☐	☐
49. Taking dietary supplements	☐	☐
50. Taking medication for weight management (i.e. fen-phen)	☐	☐
51. Experiencing frequent headaches	☐	☐
52. Considered a touchy person	☐	☐
53. Often unhappy or depressed	☐	☐
54. A smoker, smoked previously or use smokeless tobacco	☐	☐
55. FEMALE – taking birth control pills	☐	☐
56. FEMALE – pregnant	☐	☐
57. MALE – prostate disorders	☐	☐

Describe anycurrent medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections, etc.) _____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____Date_____

Doctor's Signature _____ Date _____

Medications

Patient Name: _____ Nickname: _____ Age:_____

Please list all over-the-counter and prescription medications, supplements, and vitamins you have taken in the last 6 months. An additional sheet is available upon request.

Drug	Dosage	Purpose

Patient Dental History

Patient Name: _____ Nickname: _____ Age:_____

Previous Dentist: _____ How long have you been a patient? _____Months/Years

Date of most recent dental exam _____ Date of most recent x-rays:_____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning sensation in your mouth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
25. Are your teeth crowding or developing spaces?	☐	☐
26. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
28. Do you clench your teeth in the daytime or make them sore?	☐	☐
29 Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
30. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
32. Have you ever whitened (bleached) your teeth? _____	☐	☐
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
34. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature_____ Date_____

Doctor's Signature _____ Date _____

Consent for Services

I authorize Bliss Family Dentistry and its employees to examine, take radiographs, photographs, study models, or any other diagnostic aid deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I authorize and consent that the doctors employ any such assistance as he/she deems appropriate.

I certify that all medical and dental information given is accurate to the best of my knowledge, and if any changes in my medical or dental history occur, I will notify Bliss Family Dentistry promptly.

There will be a $25.00 missed or late cancellation fee charged unless your appointment is canceled at least 48 hours in advance. We reserve the right to have future appointments prepaid or not pre-book your appointments but allow you to be on a cancellation list. If you miss 3 missed appointments without adequate cancellation time, you may be dismissed as a patient from the practice. If you arrive more than 15 minutes late for your scheduled appointment, you may be asked to reschedule your appointment to another time and/or day and be subject to the missed appointment fee.

I certify that my above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental policy, including benefits, limitations, and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I further authorize the release of any information, including diagnosis, radiographs, and records of any treatments or examinations rendered to my insurance company, consulting professionals, or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents regardless of insurance coverage. I understand that payment is due when services are rendered. Any other arrangements for payment must be made prior to treatment. I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

I have read and understand the HIPPA policy.

_____ _____

Signature of patient, parent, or guardian Date

No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment

Bliss Family Dentistry defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 48 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show" $25 Fee

1. Confirm your appointment
2. Arrive 5-10 minutes early
3. Give 48 hours' notice to cancel appointment

1. **Appointment Confirmation**- Bliss Family Dentistry will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will need to contact Bliss Family Dentistry at (915)213-3555 two business days before the appointment – otherwise the appointment will be canceled and marked as a "no-show".
2. **Always Arrive 5-10 Minutes Early**- When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.
3. **Give 48 Hours' Notice if You Need to Cancel**- When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 48 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 48 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 3 or more appointments within a year you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your dental provider
2. If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled
3. Only emergency medical/dental treatment will be offered within the first 30 days of dismissal
4. Reapplication to the clinic after a six month period after initial dismissal letter will be considered by the dental provider.

I have read and understood the Bliss Family Dentistry will "No Show" Policy as described above.

_____ _____

Patient Signature Date