Welcome to our office!

Please take a moment to share with us your information…

Name: ____ Preferred name or nickname:

Home address/City/State/Zip Code:

____

Home telephone number: Work phone:

Cell Phone: ____________________________________ Email address: ____

Date of birth: ___________________________________ Social security number: ___________________________________

Your occupation: _________________________________ Marital Status: ____

If you are a student, please list the school you are attending: ____

How did you hear about our practice? ____

Preferred Contact : Email ___ Text_____ Call____ Preferred Time ____________________

Insurance information…

Do you have dental insurance? ___________________ Primary card holder's name: _______________________________

Primary card holder's employer: Insurance company name:

Insurance company phone number: ________________ Insurance company group number: ________________________

Primary card holder's date of birth: _________________ Primary card holder's social: _______________________________

Please list the member or subscriber ID number if one is provided: ____

Your relationship to the card holder: Self Spouse Child

Emergency contact information…

Whom may we notify in case of an emergency?

Best contact number: ____

Address: ____

Medical History

Please answer the following questions so that we may provide optimum care for you…

Are you currently under the care of a medical doctor?______________________________

If so, please provide the Doctors name and reason for care:

____

Are you currently taking any prescription drugs? Please list:

____

Do you have any allergies? Please list: ______________________________

Are you pregnant or suspect you may be pregnant?____________ Do you take birth control?____________

Have you had any major surgeries in the last five years? Please list date:

Do you have pins, plates, screws, or artificial joints?______________________________

Have you ever taken Fen Phen or Redux? If so, did you have a cardiology exam?

Do you use more than two pillows to sleep at night? _________ Do you wake up with shortness of breath? _________

Have you lost or gained more than ten pounds in the last year? _______ Are you on a special diet?____________

Have you ever been informed of a heart murmur, condition, or had heart surgery? Please explain in detail:

Have you ever bled excessively? Have you ever had complications with anesthesia?

Please circle any of the following and provide a date if you have had or currently have:

High/low blood pressure:	Rheumatic Fever:	Glaucoma (wide or narrow?):	Angina Pectoris:	
Tuberculosis:	Chemotherapy:	Mitrovalve Prolapse:	Liver Disease:	HIV:
AIDS:	Hepatitis A, B, or C:	Chest pain:	Yellow Jaundice:	Anemia:
Blood Transfusion:	Hemophilia:	Sickle Cell Disease:	Kidney Trouble:	Stroke:
Congenital Heart Lesions:	Scarlet Fever:	Hay Fever:	Narcotic addiction:	Hives:
Sinus Trouble:	Asthma:	Emphysema:	Arthritis:	
Rheumatism:	Cortisone Meds:	Psychiatric Treatment:	Drug Addictions:	Epilepsy:
Fainting:	Nervousness:	Eating Disorder:	Diabetes:	
Thyroid Disease:	Ulcers: Cold Sores:	X-ray or Cobalt Treatment:	bisphosphonates (osteoporosis):	

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history?

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.

____

Patient Signature: ______________Date:_________ Doctor's Signature:______________ Date:_________

Dental History

Please answer the following questions so that we may provide optimum care for you…

Reason for today's visit: ____

How long has it been since you last dental visit? Were dental x-rays taken?

Previous Dentist's name: ____________________ Previous Dentist's phone number: ____________________

Was there any recommended dental treatment not completed?

Do you feel nervous about having treatment? Yes No

Have you ever had an unpleasant experience at a dental office? Yes No

Are your teeth sensitive to: Heat Cold Biting Pressure Sweets?

Do you smoke or use tobacco? yes No

Do you clench or grind your teeth? Yes No

Do you have frequent head, neck, or shoulder aches? Yes No

Have you ever had braces or other orthodontic treatment? Yes No

Does food constantly get stuck between your teeth? Yes No

Do you brush and floss daily? Yes No

Do you gums ever bleed when you brush or floss? Yes No

Is there ever an unpleasant taste or odor in your mouth? Yes No

Have you ever had a *functional bite assessment* performed? Yes No What is a bite assessment?

In general, how do you feel about your overall dental health? ______________________________

Are you dissatisfied with the way your teeth look? If so, please explain (i.e. shape, color, and aesthetics):

____

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? ____

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.

____

Patient Signature: Date: Doctor's Signature: Date:

Office Policies

Thank you for allowing us to care for you! Our goal is to provide you with quality dental care and to serve you in a comfortable and professional atmosphere. Our patient's health is important to us. Patients with financial concerns are encouraged to speak with us so that we can customize a treatment approach that best suits your budget. Below you will find helpful information in regards to Payments, Appointments, Reservation Fees, Insurance, and our obligations to you. **Please initial each paragraph and sign at the bottom.**

PAYMENTS: **(Initial) ________**

- We accept **Cash**, **Checks**, **Money Orders**, **VISA**, **MasterCard**, **Discover** and **CareCredit**.
- Payment is due at the time services are rendered.
- Payment in full (excluding insurance) may qualify for a discount.
- Treatment exceeding $500.00 may qualify for special financial arrangements.
- **CareCredit** offers payment options up to 12 months with zero interest so you can get the care you need. Visit www.CareCredit.com to learn more or to fill out an application online. Our team can also help answer any questions you may have.

RESERVED APPOINTMENTS: (Initial) __________

We have an obligation to you and our other patients to schedule appointments in a timely manner. We value your time and we promise to make every effort to get you in and out quickly while maintaining a comfortable setting.

- As a courtesy, we provide appointment reminders and confirmations via calls/texts/emails
- Reserved appointments are specifically held for you and nobody else.
- We operate based on an appointment book and we will make every effort to accommodate walk-ins. Wait times may be longer than usual for walk-ins.
- Reservation fees are required to reserve treatment appointments over 30 minutes long.
- If you cancel or reschedule after your confirmation call, which is one week prior to your appointment, a broken appointment fee of $50 will be applied for recare appointments.

A 20% deposit is required to reserve treatment appointments. Your 20% deposit will apply towards your scheduled treatment or will be forfeited if a cancellation is made after confirmation without a written excuse for absence. An additional 20% deposit will be required to reserve another appointment, thereafter. Reservation fees are due upon scheduling and a credit card will be held on file.

Cardholder Name: ____

Card Number: ____

RESERVATION FEES: (Initial) __________

Sweet Tooth Dental Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 512-448-9669.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. Sweet Tooth Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Sweet Tooth Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Sweet Tooth Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Sweet Tooth Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict the Use of Information

You have the right to request restrictions on uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I have reviewed Sweet Tooth Dental Privacy Policy.

Signed: __________________ Date: ____________________

Please take a moment to tell us about your smile so that we may better serve your individual needs.

Patient Name:____

When I see a picture of myself, the first thing I notice about my smile is:

____

Some things that I consider attractive in other people's smiles are:

____

**Please "✔" the statements below that apply to you.

☐ I wish my teeth were straighter.

☐ I wish I had a broader smile.

☐ I think some of my teeth are too small.

☐ I think some of my teeth are to large.

☐ I wish my teeth were whiter with regard to their color.

☐ I think my gums show too much when I smile.

☐ Because I am not totally pleased with my teeth, I sometimes hesitate to smile.

☐ I feel as though I don't really know all of the options available to me for enhancing my smile.

☐ Concerns over what the end results might look have been a factor in my not having esthetic dentistry in my mouth.

☐ Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.

☐ I feel as though I could do a better job protecting the habit the health of my teeth and gums,and therefore,the longevity of my smile.