1140 Rock Spring Rd
Apopka, FL 32712
(407) 889-8300
info@allsmilesfamily.com

ALL SMILES FAMILY DENTAL

NEW PATIENT INFORMATION

Today's Date: ____/____/____

Last Name:	First Name:	Middle Name:
Preferred Name:	Social Security: __ __ __ - __ __ - __ __ __ __	
Home Phone:	Cell Phone:	Work Phone:
E-Mail Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender (Check one): □ Male □ Female □ Other	
Occupation:	Marital Status (Check one): □ Single □ Married □ Divorced □ Other	
Emergency Contact Name:	Relationship:	Phone:
Preferred Pharmacy:	Pharmacy Phone Number:	

If you are completing this form for another person, what is your name and relationship to that person?

Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

What is your preferred method of communication? (Check all that apply) □ Text □ Email □ Home Phone □ Cell Phone

I understand that modern connectivity now includes the widespread use of text messaging and email communications. I hereby authorize and consent to All Smiles Family Dental to send me, my dependents and family members text message alerts, reminders and direct communications via the text messaging system. Any/all rates are my responsibility. Text messages and emails may include information about limited time specials and other promotional information. I understand that I may opt out of this at any time by:

1. Emailing info@allsmilesfamily.com
2. Texting the dental office phone number "I wish to opt out of the text messaging service"
3. Confirming via phone call or in person communication of my desire to be removed from the text messaging platform.

Who should we thank for referring you? (Check all that apply)

□ Another patient (Name): _____		□ Insurance	□ Post Card
□ Our Website	□ Place of Employment	□ Google	□ Yelp
□ Event/Charity	□ Location	□ Social Media	□ Other: _____

INSURANCE INFORMATION

Policy Holder:	Policy Holder Date of Birth: / /
Social Security #	Relationship to Patient:
Employer:	Insurance Company:
Subscriber I.D. #	Group #

Please read carefully below

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE ALL SMILES FAMILY DENTAL TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND ALL SMILES FAMILY DENTAL AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO ALL SMILES FAMILY DENTAL AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

Patient Signature: _____ Date: ____/____/_____

MEDICAL HISTORY

Patient Name:

Name of Physician:	Physician Phone Number:
Date of most recent Physical Exam:	Has a physician ever recommended antibiotics before dental work? □ Yes □ No

What is your estimate of your general health? (Check One) □ Excellent □ Good □ Fair □ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury If yes, explain: _____	□	□
2. An allergic or bad reaction to any of the following: □ Aspirin □ Ibuprofen □ Acetaminophen □ Codeine □ Penicillin □ Erythromycin □ Tetracycline □ Sulfa □ Local Anesthetic □ Fluoride □ Chlorhexidine (CHX) □ Iodine □ Metals (nickel, gold, silver) □ Latex □ Nuts □ Fruit □ Milk □ Red dye □ Other: _____	□	□
3. Heart problems, or cardiac stent(s) within the last 6 months	□	□
4. History of infective endocarditis	□	□
5. Artificial heart valve, repaired heart defect (PFO)	□	□
6. Congestive heart failure / Congenital heart disease	□	□
7. Coronary artery disease	□	□
8. Pacemaker or implanted defibrillator	□	□
9. Artificial joints	□	□
10. Heart murmur	□	□
11. Rheumatic fever or scarlet fever	□	□
12. □ High or □ Low blood pressure	□	□
13. Heart attack or stroke	□	□
14. Anemia or another blood disorder	□	□
15. Prolonged bleeding due to a slight cut (or INR>3.5)	□	□
16. Breathing problems: □ Asthma □ COPD □ Bronchitis □ Sinus congestion □ Pneumonia □ Emphysema □ Shortness of Breath □ Sarcoidosis	□	□
17. Chronic ear infections, tuberculosis, measles, chicken pox	□	□
18. Kidney disease or transplant	□	□
19. Hepatitis, liver disease or jaundice	□	□
20. Vertigo, fainting, dizziness	□	□
21. Thyroid, parathyroid or calcium deficiency	□	□
22. Hormone deficiency or imbalance (e.g. polycystic ovarian syndrome)	□	□
23. High cholesterol or taking statin drugs	□	□
24. Diabetes □ Type 1 or □ Type 2 HbA1C = _____	□	□
25. Stomach or duodenal ulcer	□	□
26. Digestive or eating disorders (e.g. acid reflux, bulimia, anorexia)	□	□
27. Arthritis or Gout	□	□
28. Gastrointestinal disease: □ GERD □ IBS/IBD □ Cerliac Disease □ Crohns	□	□
29. Tuberculosis	□	□
30. Tonsillitis	□	□
31. Post-traumatic stress disorder (PTSD)	□	□

	YES	NO
32. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)	□	□
33. Autoimmune diease (e.g. rheumatoid arthritis, lupus, scleroderma)	□	□
34. Glaucoma	□	□
35. Atrial Fibrillation (A-Fib)	□	□
36. Head or neck injuries	□	□
37. Epilepsy, convulsions (seizures)	□	□
38. Neurologic disorders (e.g. Alzheimers, dementia, prion disease, Parkinsons)	□	□
39. Viral infections (cold sores or other)	□	□
40. Bacterial infections (lyme disease or other)	□	□
41. Any lumps or swelling in the mouth		
42. Hives, skin rash, hay fever	□	□
43. STDs / HPV / STI	□	□
44. Hepatitis (Type _____)	□	□
45. HIV/AIDS	□	□
46. Cancers, tumors or abnormal growths	□	□
47. Radiation therapy	□	□
48. Chemotherapy, immunosuppresive medications	□	□
49. Difficulties with stress management	□	□
50. Psychiatric treatment, antidepressants, mood stabilizing meds	□	□
51. Concentration problems or ADD/ADHD	□	□
52. History of alcoholism	□	□
53. Cortisone treatments	□	□
54. Back problems or trouble laying flat	□	□
55. Sleep problems: □ Sleep Apnea □ Snoring □ Restless Sleep □ Bedwetting	□	□
56. Hypoglycemia	□	□
57. Traumatic brain injury or concussion	□	□
58. Recreational drug use/chemical dependency If yes, explain: _____	□	□
59. Do you smoke, vape or currently use other tobacco products?	□	□
60. Have you previously smoked, vaped or used other tobacco products?	□	□
61. Do you have a known genetic disorder?	□	□
ARE YOU:		
62. Presently being treated for any other illnesses	□	□
63. Aware of a change in your health in the last 24 hours	□	□
64. Often exhausted or fatigued	□	□
65. Suffering from chronic pain or frequent headaches	□	□
66. Suffering from anxiety	□	□
67. Often unhappy or depressed	□	□
68. Taking birth control pills	□	□
69. Currently pregnant or nursing? If so, how many weeks? _____	□	□
70. Diagnosed with a prostate disorder	□	□

MEDICAL HISTORY (continued)

Please list ALL medications, supplements, vitamins, antibiotics, and/or probiotics taken in the last 2 years

Drug	Purpose	Drug	Purpose

Are there any other medical conditions you are currently diagnosed with, being treated for or were not mentioned above? □ Yes □ No

If Yes, please describe below:

Have you ever taken any of the following blood thinners? (Check all that apply)

□ Warfarin (Coumadin)	□ Apixaban (Eliquis)	□ Innohep (Heparin)
□ Clopidogrel (Plavix)	□ Rivarixaban (Xarelto)	□ Dabigatran (Pradaxa)
□ Edoxaban (Savaysa)	□ Prasugrel (Effient)	□ Ticagrelor (Brilinta)
□ Aspirin	□ Ticlid	□ Enoxaparin (Lovenox)

Have you ever taken any of the following bisphosphonates? (Check all that apply)

□ Risedronate (Actonel/Atelvia)	□ Alendronate (Fosamax)	□ Ibandronate (Boniva)
□ Zolendronate (Reclast/Zometa)	□ Pamidronate (Aredia)	□ Etidronate (Didronel)
□ Denosumab (Prolia/Xgeva)	□ Methotrexate	

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS

Note: It is important for both the doctor and the patient to talk honestly about the patient's health before dental treatment starts. I have answered the above questions completely, accurately and to the best of my ability.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

DENTAL HISTORY

Patient Name:	Has a prior dentist ever recommended antibiotics before dental work? □ Yes □ No
Previous Dentist:	How long had you been a patient? _____ months/years
Date of most recent dental exam:	I see my dentist every: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not Routinely
Date of most recent dental x-rays:	Date of most recent treatment (other than cleaning):

How would you rate the condition of your mouth? (Check One) □ Excellent □ Good □ Fair □ Poor

WHAT IS YOUR IMMEDIATE CONCERN: _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
Personal History		
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, and at what age? _____	□	□
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	□	□
Periodontal History (Gum & Bone)		
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	□	□
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	□	□
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	□	□
10. Is there anyone with a history of periodontal disease in your family?	□	□
11. Have you ever experienced gum recession, or can see more of the roots of your teeth?	□	□
12. Have you ever had any teeth become loose on their own (without injury), or feel them move when chewing?	□	□
13. Have you experienced a burning, painful sensation, or metallic taste 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, not enough, or do you have difficulty swallowing or chewing 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. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	□	□
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	□	□
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	□	□
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	□	□
25. Are your teeth becoming more crooked, crowded, or overlapped?	□	□
26. Are your teeth developing spaced or becoming more loose?	□	□
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	□	□
28. Do you place your tongue between your teeth or close your teeth against your tongue?	□	□
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	□	□
30. Do you clench or grind your teeth together in the daytime/nighttime or ever make them sore?	□	□
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	□	□
32. Do you wear or have you ever worn a bite appliance? (i.e. nightguard)	□	□
Smile Characteristics		
33. Is there anything about the appearance of your mouth (smile, lips teeth gums) that you would like to change (color, spaces, size, shape, display)?	□	□
34. Have you ever bleached (whitened) your teeth?	□	□
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	□	□
36. Have you been disappointed with the appearance of previous dental work?	□	□

PHOTOGRAPH AUTHORIZATION AND CONSENT AGREEMENT

Patient Name: _____

I authorize and consent to the Dentist and the All Smiles Family Dental staff taking Photographs of Patient before, during, and after the dental treatment provided by the Dentist. The Dentist and All Smiles Family Dental may use the Photographs for clinical documentation, lab shade match and lab communication methods, educational purposes in lectures, demonstrations, advertising (including website publication, social media, newspapers, magazines, television) and professional publications (dental magazines and journals). Photographs include video, still, or any other electronic or mechanical means or format for recording or reproducing images.

Patient releases Dentist and All Smiles Family Dental from all liability that may arise from the Photographs, and Patient agrees to indemnify and hold Dentist and All Smiles Family Dental harmless from any and all claims and costs (including attorney fees) arising out of or in any way connected with the Photographs.

Patient or Parent/Guardian has entered into this agreement willingly and waives any right to compensation for the Photographs. Patient or Parent/Guardian has read, understands, and agrees to all of the terms and conditions. Patient is eighteen (18) years or older or Patient's Parent/Guardian has signed below. This is the entire Agreement between Patient and Dentist concerning the Photographs and it may not be altered, superseded, or otherwise modified except in writing and signed by Patient or Parent/Guardian and Dentist.

I have read and understand the above information.

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

□ I do NOT authorize any information to be discussed with any family members or friends.

□ I authorize information about treatment or appointments to be discussed with the

following person(s): _____

I have read and understand the above information.

_____ _____

Patient Signature Date

FINANCIAL POLICY

Thank you for choosing All Smiles Family Dental our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making cost of optimal care as easy and manageable for our patients as possible by offering several payments options.

Payment Options:

You can choose from:

- Check, Visa, MasterCard, American Express or Discover Card
- Please note we are charging a 3% supplemental/merchant fee for all credit card transactions.
  - Payment via cash or check can avoid this fee.
- Convenient Monthly Payment Options (1) from Care Credit, Cherry, or Proceed Finance
  - Allows you to pay overtime
  - No annual fees or pre-payment penalties

Please note:

All Smiles Family Dental requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. (2)

We do ask that you give us a 24-hour notice prior to your appointment to change or reschedule. Patients are subject to a $50 no show fee.

All Smiles Family Dental charges $50.00 for returned checks.

If you have any questions, please do not hesitate to ask.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

(1) Subject to credit approval
(2) However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.