SINGH SMILE CARE
COSMETIC AND IMPLANT DENTISTRY

Patient Information

Name: _____
Last First Middle Initial Preferred Name

Address: _____
City State Zip

SSN: _____ Date of birth: _____ Sex: ☐ Male ☐ Female

Phone: Home: _____ Cell: _____

E-mail: _____ Preferred contact method: ☐ Phone ☐ Text ☐ E-mail

Employer: _____ Phone Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Spouse/Partner's Name: _____ Phone: _____

How did you hear about our office? _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Insurance – Primary

Subscriber name: _____ Relationship to patient _____ Subscriber DOB: _____

Insurance name: _____ Subscriber ID/SSN: _____

Group name/ Employer: _____ Group #: _____

Insurance Co phone #: _____

Insurance – Secondary

Subscriber name: _____ Relationship to patient _____ Subscriber DOB: _____

Insurance name: _____ Subscriber ID/SSN: _____

Group name/ Employer: _____ Group #: _____

Insurance Co phone #: _____

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

3201 W. Peoria Ave Ste A103 Phoenix, AZ 85029 • P: (623) 934-6400 • F: (623) 934-6406
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Medical History and Information

Conditions

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Allergies/Sinus Problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer (type) _____
  - ➢ Active? Y or N
  - ➢ Diagnosed? _____
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Diabetes (type) _____
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV or Aids
- ☐ Hemophilia
- ☐ Hepatitis (type) _____
- ☐ High Blood Pressure
- ☐ Joint Replacement
  - ➢ Pre-Med Y or N
- ☐ Kidney Problems
  - ➢ Dialysis Y or N
  - ➢ Fistula: Location: _____
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Organ Transplant
  - ➢ Kidney Y or N
  - ➢ Liver Y or N
  - ➢ Other: _____
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Heart Conditions:

- ☐ Angina Pectoris
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defect
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Other:_____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracyclin
- ☐ Other: _____

Do you have a history of:

Y	N	
☐	☐	Smoking/Tobacco/Vape (circle one)
☐	☐	Drug abuse
☐	☐	Alcohol Abuse

Women only:

Y	N	
☐	☐	Birth control?
☐	☐	Pregnant? If yes, # of weeks _____
☐	☐	Nursing

List all/any surgeries and dates:

1. _____
2. _____
3. _____
4. _____

List of Medications:

(Including over the counter, medicinal and vitamins)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you currently under physician's care?

(Cardiologist, OBGYN, Orthopedic, etc.)

1. Doctor/Surgeon's name: _____

   Phone #: _____
2. Doctor/Surgeon's name: _____

   Phone #: _____

I certify to the above statements regarding my medical condition. It is my responsibility to inform the office of any changes of the information provided on this form.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

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Your Smile Survey

Patient Name: _____ Date: _____

Initial Concern: _____

Date of last dental visit: _____ Date of last xrays: _____

Date of last dental cleaning: _____

1. Do you love your smile? Y or N
2. Is there anything you would like to change?
   - ☐ Color
   - ☐ Spaces
   - ☐ Size/ Shape
   - ☐ Old fillings/ dental work
   - ☐ Other: _____
3. Are you interested in learning more about:
   - ☐ Teeth Whitening
   - ☐ Fillings (bonding)
   - ☐ Partials/Dentures
   - ☐ Crown and Bridge
   - ☐ Implants
   - ☐ Night Guard
   - ☐ Lumineers
   - ☐ Botox
   - ☐ Clear Braces
   - ☐ TMJ
4. Are you interested in a smile makeover with no shots or drilling? Y or N
5. If you had a magic wand that could enhance anything about your smile, what would you change? _____

   _____

   _____

   _____

6. Have you had an upsetting experience in a dental office? Y or N
7. Do you feel nervous about having dental treatment? Y or N
8. Is there anything else about having dental treatment that bothers you? Explain: _____

   _____
9. Why did you leave your last dentist? _____

   _____

   _____
10. What did you like most about your last dentist? _____

    _____
11. How can we better accommodate you during your dental visit?

    _____

    _____

    _____
12. Are you having pain at this time? Y or N
13. Have you ever had:
    a. Orthodontic Treatment: Y or N
    b. Oral Surgery: Y or N
    c. Periodontal Treatment: Y or N
    d. Your Teeth or bite adjusted: Y or N
14. Have you noticed any loosening of your teeth? Y or N
15. Does food tend to get caught between your teeth? Y or N
16. Do you suffer from pain and/or swelling of your gums? Y or N
17. Do your gums often bleed when you brush your teeth? Y or N
18. Problems of the jaw – Have you experienced:
    a. Clicking of the jaw? Y or N
    b. Pain (Joint, Ear, Side of Face)? Y or N
    c. Difficulty in opening and closing? Y or N
    d. Difficulty in chewing? Y or N
19. Habits - Do you:
    a. Clench or grind your teeth while awake or asleep? Y or N
    b. Bite your lips or cheeks regularly? Y or N
    c. Hold foreign objects with your teeth? Y or N

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CANCELLATION POLICY

We make every effort to schedule out patients with the appropriate amount of time for their treatment and to see them on time. We expect the same effort from our patients in making it to their scheduled appointments.

Policy requires that our patients provide at least **48 hour** notice when needing to cancel an appointment. Failure to provide such short notice may result in a **$75 per hour** "cancellation" fee.

Although rarely an issue, patients that do not show for three consecutive appointments may be discharged from the practice.

I have read and understand the cancellation policy. Initial:_____

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize Singh Smile Care to release any information including the diagnosis, radiographs and treatment notes rendered me during the period of medical/dental care to third party payers (insurance) and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to Singh Smile Care insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered on my behalf, or the behalf of my dependents, leaving me responsible.

If I do not pay the entire balance within 90 days of the monthly billing date, a billing fee of 1.5% per month will be charged on the balance owed. I realize that failure to keep my account current will result in Singh Smile care being unable to provide additional medical/dental services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balance.

*** * * PLEASE NOTE * * * As a courtesy to you, we will file insurance on your behalf and estimate your portion that is due and payable at the time of service. It is your responsibility to provide us with correct, current insurance information and see that your insurance company pays in a timely manner.**

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

At Singh Smile Care, we believe that you deserve the best care. That's why we are always present you with the best solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. Here are some things you should know:

- Singh Smile Care does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, American Express, cash and checks. If you are in need of an extended finance option, we also work with CareCredit and Lending Club, whom offer 6 or 12 month "same as cash" designed to meet your treatment plan needs on approved credit. (Please note the minimum charge requirement to meet 6 or 12 month payment plan).
- Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- We currently accept most private care insurance plans (plans do not require you to select a dentist from a list or require our office to accept a reduced fee for service). Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is only an estimate. If you would like you know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you a more accurate out of pocket figure.
- We will bill your insurance company as a courtesy. If the insurance does not pay within 90 days, Singh Smile Care reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

I agree with the above conditions.

Patient Name (printed): _____ Date: _____

Patient/Guardian Signature: _____

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NOTICE OF PRIVACY PRACTICES

Privacy of your personal information is an important part of our office just as providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us.

- Singh Smile Care is required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy Practices that is described in the Notice while it is in effect. This Notice takes effect April 15, 2003 and will remain in effect until we replace it.
- We may use and disclose health information about you for treatment, payment, and health care operations (which does include communication with your dental specialist or physician).
- We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, or letter).
- We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree we may do so.
- We may use or disclose your health information when we are required to do so by law. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes.
- We will not use or disclose your health information for any reason other than those listed without your written authorization.
- We will not use your health information for any manner of direct or indirect personal gain or other unauthorized use.
- We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law.

I have reviewed the above information regarding the privacy practices of Singh Smile Care. I consent that Singh Smile Care can collect, use and disclose personal information as set above in the information about the office's privacy policies.

Patient Name (printed): _____ Date: _____

Patient/Guardian Signature: _____

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