PEABODY SMILE DESIGN

Welcome! Thank you for choosing Peabody Smile Design, we're glad you're here. We will strive to provide you with the best possible care without pressure and advice without obligation. To help us meet all your dental health care needs, please fill out this form. If you have any questions or need assistance, please ask us- we are happy to help.

ALL ABOUT YOU:

First Name:_____ Last Name:_____ Middle:_____ Jr/Sr:_____

Social Security #:_____ Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell:_____

Email Address:_____

Emergency Contact:_____Phone:_____

Primary Language:_____ Interpreter Needed: Yes No

How did you hear about us? _____

Are you nervous about coming to the dentist? Yes No A little Bit

What would you change about your last dental experience?_____

If you could make your teeth be any way without regard to time or cost, what would you change about your smile?

_____

INSURANCE INFORMATION:

Do you have Dental Insurance(circle): Yes No

Primary Insurance			
Subscriber Name		Date of Birth	
Subscriber ID#		Insurance Group #	

As payment is expected at time of service, we offer the following methods of payment for your convenience. Please circle the option you prefer : Cash Debit/Credit Card Our In-House Membership Plan Care Credit

Release

I certify that I, and/or my dependent(s), have insurance coverage with _____(name of insurance co.) and assign directly to Peabody Smile Design all insurance benefits. For any/all for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Peabody Smile Design may use my healthcare information and may disclose such information to the above mentioned company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This content will stay in effect as long as payments for rendered services have been paid off and I am a patient with Peabody Smile Design.

_____ _____ _____

Signature of Patient, Parent or Guardian Relationship to the patient (if under 18 years old) Date

MEDICAL HEALTH HISTORY

Please circle if you have, or had, any of the following?

Heart Problems	Diabetes	Stroke
Chest pain	Intestinal Disorders	Fainting spells
Shortness of breath	Ulcers	Epilepsy
High/Low blood pressure	Weight gain/loss	Tuberculosis
Heart Murmur	Kidney/bladder diseases	COPD
Heart Valve	Swollen Neck/glands	Persistent cough
Artificial Heart Valve	Bone or Joint problems	Thyroid problems
Pacemaker	Arthritis	Asthma
Blood Problems	Chronic Back/neck pain	Psychiatric Care
Easy Bruising	Joint replacement	Nervous disorders
Blood transfusion	Glaucoma	Cancer/ Tumor
Abnormal bleeding	Rheumatic Fever	Chemotherapy
Anemia	HIV/AIDS	Radiation Treatment
Seizures	Herpes or other STDs	Premedication required
Hay Fever	Liver Disease	Substance abuse
Sinus problems	Hepatitis, Jaundice	Frequent headaches

Any disease, condition, problem not listed_____

Do you drink alcohol ? If yes, how much?_____ Do you smoke? How much?_____

Are you allergic, or have you reacted adversely to any of the following? Please circle all that apply.

Local Anesthetics	Latex
Penicillin or other antibiotics	Codeine
Sulfa drugs	Ibuprofen
Acetaminophen	Aspirin
Other_____	**None**

Women:

Are you taking contraceptives or other hormones	Yes	No
Are you pregnant	Yes	No
If so, expected due date: _____		
Are you nursing?	Yes	No
Have you reached Menopause?	Yes	No

During the past 12 months, have you taken any of the following?

Anticoagulants	Yes	No
Blood Pressure medication	Yes	No
Aspirin	Yes	No
Bisphosphonates	Yes	No
Nitroglycerin	Yes	No
Cortisone (steroids)	Yes	No

Please list all other:

_____

_____

_____

_____

_____

_____
Signature of Patient, Parent or Guardian

_____
Date

_____
Signature of Doctor

_____
Date

PEABODY SMILE DESIGN

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Annual Informed Consent for Treatment

I hereby voluntarily request and authorize Peabody Smile Design to render the dental services listed below as deemed necessary, to myself/or my child. Services include diagnostic: x-rays, exams, treatment plan. Preventative care: cleanings, fluoride treatment, sealants.
I understand that I have the right to question or refuse this or any treatment at any time.

Initials _____

Medications, Substances and Medical Conditions

I understand that antibiotics, analgesics (Pain medicines), anesthetics, latex, and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting and/or more severe allergic reactions. I have informed the dentist of any known allergies and/or medical conditions, including possible pregnancy.

Initials _____

Changes to Treatment Plan

I understand that during the treatment it may be necessary to change or add procedures because of conditions found during treatment that were not evident during the initial examination Some of these changes are, but not limited to, root canal therapy that is necessary following the placement of "deep fillings", or crowns recommended after placing of "deep fillings". I authorize my dentist to make any changes and/or additions to treatment plan as necessary.

Initials _____

Dental Benefits

I understand that the treatment my dentist recommends is based on what he/she determines is best for my dental health, and not necessarily based on what an insurance plan will pay. Therefore I understand that my insurance (if any)may not cover all aspects of my treatment plan and I will be financially responsible for any treatment not covered by the insurance plan. understand the treatment plan proposed to me is an estimate of insurance benefits and my actual coverage may differ due to frequency limitations, group coverage etc. I acknowledge that I am responsible for any balance remaining in the event that my insurance coverage is terminated for any reason.

Initials _____

I understand that dental treatment has potential risks and consequences. Likewise, so does the refusal or denial of dental treatment. Untreated conditions may lead to pain, swelling, infection, tooth loss and/or other severe consequences.I have had the opportunity to have all my questions answered by the dentist.

_____ _____

Signature of Patient, Parent, Legal Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Parent, Legal Guardian or Personal Representative Relationship to Patient

_____ _____

Doctor's Signature Date

PEABODY SMILE DESIGN

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Notice of Privacy Practices

We are committed to protecting health information in compliance with the law. The Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information
- how we may use and disclose the health information that we keep about you
- your rights relating to your personal health information
- our rights to change our Notice of Privacy Practices
- how to file a complaint if you believe your privacy rights have been violated
- the conditions that apply to uses and disclosures not described in this Notice
- the person to contact for further information about our privacy practices

Cancellation Policy

Our goal is to provide high quality care to our patients. In fairness to other patients and the office staff, we require at least 24 hours notice when changing or cancelling an appointment as we reserve that time and prepare in anticipation of serving you. If you require to cancel or reschedule your appointment, we request you to do so in advance. Any cancellation or reschedule requests need to be made more than 24 hours from your scheduled appointment time, otherwise you will be responsible for a $50 cancellation fee which will be automatically charged to your credit card on file or account. If we are unreachable, voicemails, texts and/or emails should be sent on your behalf to confirm your cancellation in a timely manner.

Patient Acknowledgement of Receipt

I,_____, hereby acknowledge that I have received a copy of a copy of the Notice of Privacy Practices.

_____ _____

Patient's Signature Date

_____ _____