

# Welcome to Smile Boutique

## Tell Us About Yourself

Date: \_\_\_\_\_ Email: \_\_\_\_\_  
Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First MI Mr. Mrs. Ms. Dr.  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M D W  
Home Address: \_\_\_\_\_  
Street City State Zip  
Home Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
DL#: \_\_\_\_\_  
When & where are the best times to reach you? \_\_\_\_\_  
Other family members seen by us: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street/PO Box City State Zip

### Neighbor or Relative Not Living With You

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

### Spouse Information

His/Her Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ DL#: \_\_\_\_\_

### Person Responsible for Account if Other Than Yourself

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_ DL#: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Street City State Zip

### Insurance Information

Primary Insurance: Dental Y/N Medical Y/N

Insurance Name: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Group#:(Plan/Policy) \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BirthDate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

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Secondary Insurance: Dental Y/N Medical Y/N

Insurance Name: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Group #:(Plan/Policy) \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BirthDate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Street/PO Box City State ZIP

### Authorization & Release

I authorize the dentist(s) to release information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Signature of Patient, Guardian, or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Please print name of Patient, Guardian, or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Former Dentist? City & State? \_\_\_\_\_

Date of last dental cleaning? \_\_\_\_\_ Date of last X-Rays: \_\_\_\_\_

### Please check any of the following that apply:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Bad Breath                | <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Blisters on lips/mouth | <input type="checkbox"/> Burning sensation on tongue |
| <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Dry mouth              | <input type="checkbox"/> Fingernail biting           |
| <input type="checkbox"/> Foreign objects           | <input type="checkbox"/> Grinding/Clenching teeth      | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Jaw pain or tiredness       |
| <input type="checkbox"/> Lip or cheek biting       | <input type="checkbox"/> Loose teeth                   | <input type="checkbox"/> Broken fillings        | <input type="checkbox"/> Mouth breathing             |
| <input type="checkbox"/> Mouth pain, brushing      | <input type="checkbox"/> Orthodontic Treatment         | <input type="checkbox"/> Pain in/around ear     | <input type="checkbox"/> Periodontal treatment       |
| <input type="checkbox"/> Sensitivity to cold       | <input type="checkbox"/> Sensitivity to hot            | <input type="checkbox"/> Sensitivity to sweets  | <input type="checkbox"/> Sensitivity to chewing      |
| <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Food collection between teeth |   | <input type="checkbox"/> Pain in jaw joints          |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Do you still have your wisdom teeth? If yes, why? \_\_\_\_\_

Do you require pre-medication before dental treatment \_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_ If not, what would you like to change? \_\_\_\_\_

## MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any over the counter or prescription medications?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

**WOMEN:** Are you Pregnant/ Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

### Are you allergic to any of the following?

- |                                  |                                      |                                  |  |                                  |                                |
|----------------------------------|--------------------------------------|----------------------------------|--|----------------------------------|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin  | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Metal |
| <input type="checkbox"/> Latex   | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Other   | If yes, please explain: _____              |                                  |                                |

### Do you have, or have you had, any of the following? Check ALL that may apply to you.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD                       | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Hives or Rash                | <input type="checkbox"/> Sinus Trouble     |
| <input type="checkbox"/> AIDS/HIV Positive              | <input type="checkbox"/> Drug Addiction                  | <input type="checkbox"/> Hypoglycemia                 | <input type="checkbox"/> Spina Bifida      |
| <input type="checkbox"/> Anaphylaxis                    | <input type="checkbox"/> Emphysema                       | <input type="checkbox"/> Irregular Heartbeat          | <input type="checkbox"/> Stomach Disease   |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Epilepsy or Seizures            | <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Angina                         | <input type="checkbox"/> Excessive Bleeding              | <input type="checkbox"/> Leukemia                     | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Arthritis/Gout                 | <input type="checkbox"/> Excessive Thirst                | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Artificial Heart Valve         | <input type="checkbox"/> Fainting Spells/Dizziness       | <input type="checkbox"/> Low Blood Pressure           | <input type="checkbox"/> Tonsillitis       |
| <input type="checkbox"/> Artificial Joints              | <input type="checkbox"/> Frequent Headaches              | <input type="checkbox"/> Lung Disease                 | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Hay Fever                       | <input type="checkbox"/> Mitral Valve Prolapse        | <input type="checkbox"/> Tumors/Growths    |
| <input type="checkbox"/> Autism                         | <input type="checkbox"/> Heart Attack/Failure            | <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Blood Disease                  | <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Parathyroid Disease          |  |
| <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> Heart Pacemaker                 | <input type="checkbox"/> Psychiatric Illness/Disorder |  |
| <input type="checkbox"/> Bruise Easily                  | <input type="checkbox"/> Heart Surgery                   | <input type="checkbox"/> Radiation Treatment          |  |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Hemophilia                      | <input type="checkbox"/> Recent Weight Loss           |  |
| <input type="checkbox"/> Chemotherapy                   | <input type="checkbox"/> Hepatitis A                     | <input type="checkbox"/> Rheumatic Fever              |  |
| <input type="checkbox"/> Chest Pains                    | <input type="checkbox"/> Hepatitis B or C                | <input type="checkbox"/> Rheumatism                   |  |
| <input type="checkbox"/> Cold Sores/Fever Blisters      | <input type="checkbox"/> Herpes                          | <input type="checkbox"/> Scarlet Fever                |  |
| <input type="checkbox"/> Congenital Heart Disorder      | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Shingles                     |  |
| <input type="checkbox"/> Cortisone Medicine             | <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Sickle Cell Disease          |  |
| Have you ever had any serious illness not listed above? | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Policy Page

We want to welcome you to our dental office. Below is a summary of our office policies which we hope will provide you with the information necessary to make informed decisions about you and your family's oral care.

## **Appointments:**

- Call Smile Boutique at 817-725-8222 24 hours prior to an appointment  
If the appointment is not going to be utilized/if the visit is being cancelled or postponed.
- We reserve the right to charge \$25 for no show appointments **without** 24 hour cancellation notice.
- Please be aware patients that arrive more than 10 minutes late for their appointments may be asked to reschedule.

## **Payments:**

- We collect all co-pays, deductibles, and co-insurance at the time of service. This is according to the benefit quote that our office obtains from your insurance company.
- We have a \$30.00 fee for all return checks.

## **Holidays:**

- The office is closed for all major holidays. For urgent and emergency care, patients are to call our office line to receive an after hours line.

## **Inclement Weather:**

- For inclement weather office hours, please check our website at [www.smileboutiquedfw.com](http://www.smileboutiquedfw.com). For urgent and emergency care when the office is closed due to inclement weather, please use the URGENT CARE and EMERGENCY CARE guidelines previously listed

I have read and understood the policies of [Smile Boutique](#) and agree to all the terms described in it.

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Parent Signature/Guardian Signature

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Date

# Smile Boutique

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Acts.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
For Office Use Only  
\_\_\_\_\_

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could **NOT** be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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#### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacies that are described in this Notice while it is in effect. This Notice takes effect 4/14/03 and will remain in effect until we replace it.

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. We reserve the right to make the changes in our privacy practices and the new terms of Notice for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information list at the end of this Notice.

#### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use and disclose your health information to obtain payment for service we provide to you.

**Payment:** We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorizations to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family & Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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 that we may do so.

**Persons Involved In Care:** We may use or disclose your health information to notify or assist in the notification or (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with and opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Service:** We will not use your health information for marketing communications without your written authorization.

**Required By Law:** We may use or disclose your health information when we are required by law to do so.

**Abuse or Neglect:** 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 may also disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.