Grant E & Mark A Smith DDS

www.sherman2thdocs.com
2011 W. Lamberth Rd. • Sherman, TX 75092
sherman2thdocs@gmail.com
(903)893-8030

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-____ (Zip Code)

Driver's License Number and State Issued

_____

_____

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

Signature of patient (or parent) _____ Date _____

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber ID and Group Plan Number

_____

_____

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber ID and Group Plan Number

_____

_____

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party/Insurance Subscriber/Parent or Guardian Information

****This does not need to be completed if the patient IS the insurance subscriber****

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

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Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ No Medical Conditions

☐ *Pre Med
☐ Allergy-Latex
☐ Arthritis/Rheumatism
☐ Blood Disease
☐ Cancer
☐ Cortisone Medicine
☐ Excessive Bleeding
☐ Heart Disease
☐ Hepatitis A/B/C
☐ Jaundice
☐ Mental Disorders
☐ OrganTransplant
☐ Radiation/Chemo
☐ Sinus Problems
☐ Swollen Ankles
☐ Tumors/Growths

☐ ADD/ADHD
☐ Allergy-Penicillin
☐ Artificial Joints
☐ Blood Thinners
☐ Chest Pains
☐ Diabetes Type I/II
☐ Fainting/Dizziness
☐ Heart Murmur
☐ High Blood Pressure
☐ Kidney Trouble
☐ Mitra Valve Prolapse
☐ Other
☐ Respiratory Problems
☐ STD/HPV
☐ Thyroid Problems
☐ Ulcers

☐ Allergies
☐ Alzheimer's/Dementia
☐ Asthma
☐ Blood Transfusion
☐ Chronic Cough
☐ Emphysema
☐ Glaucoma
☐ Heart Surgery/Attack
☐ Hip Replacement
☐ Leukemia
☐ Nervous Disorders
☐ Pacemaker/Stents
☐ Rheumatic Fever
☐ Stomach Problems
☐ Tuberculosis

☐ Allergy-Codeine
☐ Anemia
☐ Autoimmune Disease
☐ Bone Marrow Transpla
☐ Cold Sores/Blisters
☐ Epilepsy/Seizures
☐ Head/Neck/Jaw Injury
☐ Hemophilia
☐ HIV/AIDS
☐ Liver Disease
☐ Neurological Problem
☐ Pregnancy
☐ Sickle Cell Disease
☐ Stroke
☐ Tuberculosis

Please clarify the conditions or alerts selected including due date if pregnant:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain. * ◯ Yes ◯ No

Pre-Med

_____

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy *

Are you taking any medications (prescription and Non-prescription) if yes please explain below * ◯ Yes ◯ No

Medications

☐ Have you taken Viagra, Revatio, Cialis or Lavitra in the last 24 hours?

☐ Have you ever taken any medications with Biophosphonates? (Fosamax, Boniva, Actonel, or others)

☐ Have you ever had an orthopedic total joint (hip, knee, elbow or finger) replacement?

Do you have any allergies and/or allergies to medications not previously listed. If yes, please explain below * ◯ Yes ◯ No

Allergies

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me. Lastly, I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of Patient/Parent or Guardian completing this form *

Response Date: ___/___/_____

Dental Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

_____

_____

Approximate date of most recent dental exam and/or dental x-rays

_____

_____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply

- ☐ Trouble getting numb
- ☐ Past/Present braces or orthodontic treatment
- ☐ Sensitive to hot, cold, biting, sweets
- ☐ Whitened or bleached your teeth
- ☐ Sores, lumps or ulcers in mouth
- ☐ Difficulty opening or closing your jaw
- ☐ Difficulty chewing
- ☐ Currently or previously wore a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Bone loss around your teeth
- ☐ Experienced gum recession
- ☐ Snores or wakes up frequently during the night
- ☐ Reactions to local anesthetic
- ☐ Experiences dry mouth
- ☐ Food gets trapped between teeth
- ☐ Drinks fluoridated water
- ☐ Biting of lips or cheeks frequently
- ☐ Popping and/or clicking of your jaw joint
- ☐ Clenching or grinding of teeth
- ☐ Partial/Dentures/Dental Implant(s)
- ☐ Diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Teeth become loose on their own (without injury)

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will submit the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Payment Options are:
CASH
CHECK
MAJOR CREDIT/DEBIT CARD
CARE-CREDIT

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I prefer to be contacted by

☐ Cell phone/Text ☐ Email ☐ Home Phone ☐ Leave a message

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

Signature of patient (or parent) _____ Date _____