New Patient Form

Name: .....

How you hear about us? ☐ Google Search ☐ Facebook ☐ Instagram ☐ Yelp ☐ Mailed Flier
☐ Banner/Sign ☐ Insurance ☐ Business card ☐ TV Add ☐ YouTube
☐ Friend ☐ Other

Did you get referred by anyone? ☐ **No** ☐ **Yes** If **Yes**, Who? .....

Reason for visit: .....

Do you have a regular dentist? ☐ **No** ☐ **Yes**

When was the last time you visited the Dentist? .....

When was the last time you got a cleaning done? .....

Have you had good dental experiences in the past? ☐ **No** ☐ **Yes**

Would you like whiter teeth? ☐ **No** ☐ **Yes**

Would you like straighter teeth? ☐ **No** ☐ **Yes**

Are you happy with your smile? ☐ **No** ☐ **Yes**

How often do you brush? ☐ 3+ times/day ☐ 2 times/day ☐ once/day ☐ once in a while ☐ rarely

How often do you floss? ☐ 3+ times/day ☐ 2 times/day ☐ once/day ☐ once in a while ☐ rarely

Do you have Dental Insurance? ☐ **No** ☐ **Yes** Name of Dental Insurance: .....

Type of Dental Insurance: ☐ None ☐ PPO ☐ HMO ☐ Medicare ☐ Medicaid ☐ Discount Plan

Any other information you would like the dental office to know about your oral health?

.....

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Patient Health History Form

Date: / /

Name: ..... Date of Birth: / / Age: .....

Address: ..... City: ..... State: ..... Zip Code: .....

Gender: ☐ M ☐ F Occupation: ..... Cell No.: ..... Home Phone: .....

Emergency Contact: ..... Relationship: ..... Phone number: .....

Dental Information

Please complete as accurately as possible.

Do you gums Bleed when you brush or floss?	☐ No	☐ Yes
Have you had any periodontal disease in past?	☐ No	☐ Yes
Have you ever had braces/Invisalign?	☐ No	☐ Yes
Are you currently experiencing dental pain?	☐ No	☐ Yes

Medical Information:

Please complete as accurately as possible.

Physicians Name: ..... Phone number: ..... Address .....

Conditions currently being treated? .....

Any serious illness, operation, or hospitalization in last 5 years? ☐ No ☐ Yes If so, what? .....

Medications currently taking: .....

Have you had joint replacement? ☐ No ☐ Yes If so when? .....

Taking any antiresorptive agent
(Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ No ☐ Yes

Do you use controlled substances (drugs)? ☐ No ☐ Yes

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes If so, how many months? .....

Allergies:

☐ Local anesthetics	☐ Latex (rubber)	☐ Codeine or other narcotics
☐ Penicillin or other antibiotics	☐ Ibuprofen or other NSAIDs	☐ Others

Check if you have had any of the following:

☐ Artificial (prosthetic) heart valve	☐ Heart murmur	☐ Bronchitis	☐ Thyroid Problems
☐ Previous infective endocarditis	☐ High blood pressure	☐ Sinus trouble	☐ Stroke
☐ Damaged valves in transplanted heart	☐ Mitral Vavle prolapse	☐ Tuberculosis	☐ Liver disease or Hepatitis
☐ Congenital Heart Disease	☐ Abnormal bleeding	☐ Cancer	☐ Epilepsy
☐ Cardiovascular Disease	☐ AIDS or HIV infection	☐ Chemotherapy treatment	☐ Fainting spells or Seizures
☐ Angina	☐ Arthritis	☐ Radiation treatment	☐ Snoring
☐ Arteriosclerosis	☐ Autoimmune disease	☐ Chest pain	☐ Kidney Problems
☐ Congestive heart failure	☐ Rheumatoid arthritis	☐ Chronic pain	☐ Osteoporois
☐ Damaged heart valves	☐ Lupus	☐ Eating disorder	☐ Swollen glands in neck
☐ Heart Attack	☐ Asthma	☐ GERD	☐ Severe headaches

Patient Health History Form

Any other condition not listed we should know? .....

Any dentist/physician recommend antibiotics prior to dental treatment? ☐ **No** ☐ **Yes**

Name of Physician/dentist who recommended antibiotics:..... **Phone:**.....

I understand that I have been as truthful in my health history as possible. I will not hold my dentist, or any member of their staff, responsible for any actions taken or not taken due to errors or omissions I made in completion of this form.

Signature of Patient/Legal Guardian: ..... Date: / /

Signature Form

- To the best of my knowledge I have not had a fever, sore throat, cough for the last 14 days. ..... (Initials)
- I have not been in contact with someone that has tested positive for covid -19 for last 14 days. ..... (Initials)
- I approve x-rays to be taken for my office procedure. ..... (Initials)
- I approve photos and/or video to be taken for use of dental records, research, and/or marketing purposes. ..... (Initials)

- I understand that I have rights to have all my medical/dental history (HIPPA) be private. I understand that The Smile Mission has an open setting with dental chairs often separated by curtains and therefore it is possible a patient nearby could learn about my medical/dental condition. I understand that only I or a legal guardian can request my dental records from The Smile Mission. I understand that the clinic may share my information to bill services, comply with the law, run the company, and/or better treat me.

Lastly, I have been informed about HIPPA Notice of Privacy Practices. ..... (Initials)

By signing this document,I approve x-rays and photos to be taken at my appointment, know my HIPPA rights and that I have ability to ask more questions about my HIPPA rights, and I am not at risk of having COVID 19.

.... Date: / /

Patient Name Patient Signature

Welcome to the Smile Mission Family

At the Smile Mission, we make dentistry affordable

Our prices are 50-90% lower than other dental clinics.

Every one deserves to smile

We have a few rules to allow us to offer lower prices

Same day treatment

A 10$ fee same day fee will be applied for small procedures

A 20$ fee same day fee will be applied for larger procedures

Missed Appointments

If you don't give 48 hour notice for missing an appointment, a missed appointment fee will applied at your next visit.

1st missed appointment:	*$5*
2nd missed appointment:	*$10*
3rd missed appointment:	*$20*
4th & more missed appointment:	*$50*

I have read and accept the Smile Mission Terms

Date: / /

Signature

info@thesmilemission.com www.thesmilemission.com