New Patient Form

Name: .....

How you hear about us? ☐ Google Search ☐ Facebook ☐ Instagram ☐ Yelp ☐ Mailed Flier
☐ Banner/Sign ☐ Insurance ☐ Snapchat ☐ TikTok ☐ YouTube
☐ Friend/Family ☐ Groupon ☐ 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: Email:

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

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 approve of receiving billing, accounting and advertising text/call/email messages from the clinic. I understand that I can opt out at any time. ……(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. I give authorization for the Smile Mission to use Gmail, outlook, google drive, WhatsApp, texting, calls, WeTransfer, and/or other similar modes of communication to communicate with their lab, call center, staff, and me about my case to allow them to continue to offer very affordable prices. I understand that email like Gmail is not considered a secure method of communication. I understand I always have the option to go to another dental office. Lastly, I have been informed about HIPPA Notice of Privacy Practices…… (Initials)
- I understand The Smile Mission makes dental YouTube, Facebook, Instagram, TikTok and other videos. I understand by being a patient at The Smile Mission – I may be recorded. I can request to not be recorded – but it is possible I might still be in the background in a video…… (Initials)
- I understand The Smile Mission is trying help me by offering great dental work at an affordable dental price. The Smile Mission tries to avoid expensive procedures including – sinus grafts, bone grafts, zygomatic implants, tissue grafts, Root canal retreatments, more. The Smile Mission will often do a filling before Root Canal treatment just to try and avoid a root canal. I understand by avoiding these expensive procedures my failure rate, infection rate, and/or complication rate could increase. I understand The Smile Mission is doing their best to treat me while keeping it affordable. …… (Initials)

- The Smile Mission has developed, invented and created many numerous trade secrets that allow the Smile Mission to offer extremely low prices. I am prohibited from disclosing technology, procedures, processes, designs, building design, forms, staff details/roles, and all types of financial, business, technical information. …… (Initials)

- The Smile Mission employees will not tolerate verbal abuse.
  The following actions will not be allowed:
  1) Raising my voice on the phone or in person at an employee
  2) Cursing at an employee
  3) Threating an employee
  If I do any of the above, I understand the cops may be called, and I will be removed immediately as a patient and I will not be given a refund. …… (Initials)

- Due to the extremely low costs and thousands of dollars I can and have saved at The Smile Mission. I now and forever release and discharge The Smile Mission and employees from any loss, costs, damages or expenses arising out of the dental services, advice, diagnosis, and treatment. I and anyone on the behalf of me will be forever foreclosed from any claim for damages arising out of the dental services, advice, diagnoses, and treatment by said Doctor, employees, including any claim made with BOARD, OSHA, or other regulatory agency, and I indemnify Doctor for the same. …… (Initials)

- I agree to not use threats to force The Smile Mission to give me additional discounts. I will not publicized The Smile Mission negatively in the media (including all social media, google, communications on the internet, texting, blogging, etc.) …… (Initials)

- If The Smile Mission can not contact me, I authorize them to contact my emergency contact and to pass on information to the emergency contact so they can pass it on to me – like important dental updates……..(Initials)

By signing this document, I was given opportunity to ask additional questions about any of the above information and understand the conditions above.

_____	_____	_____
PatientName	Patient Signature	Date

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.

All missed or cancelled Appointments (with less than 48 hours notice) will be charged a **$20** fee.

Todas las citas perdidas o canceladas (con menos de 48 h de notificación) tendrán un recargo de **$20**

I have read and accept the Smile Mission Terms

Date: / /

_____

Signature

info@thesmilemission.com www.thesmilemission.com