New Patient Form

Name: _____

How you hear about us? ☐ Google Search ☐ Facebook ☐ Instagram ☐ Yelp ☐ Mailed Flier
☐ Banner/Sign ☐ Insurances ☐ 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?

_____

_____

_____

_____

_____

_____

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 your gums bleed when you brush or floss?	☐ No	☐ Yes
Have you had any periodontal disease in the 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: .....

Condition currently being treated? .....

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

Medications currently taken: .....

have you had a joint replacement? ☐ No ☐ Yes if so, when? .....

Do you take 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, sniffing, chewing, bidis)? ☐ No ☐ Yes

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

Allergies:

☐ Local Anesthesia ☐ Latex (rubber) ☐ Codeine or other narcotics
☐ Penicillin or other antibiotics ☐ Ibuprofen or other NSAIDs ☐ Others: .....

Check if you have had any of the following options:

☐ 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
☐ Rheumatold 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
☐ Kid ney Problems
☐ Osteoporois
☐ Swollen glands in neck
☐ Severe headaches
☐ Diabetes

Patient Health History Form

Any other conditions not listed we should know?----------

Any dentist/physician recommended antibiotics before 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 action taken or not taken due to errors or omissions I made in completion of this form.

Patient Name	Patient Signature	Date

Refund Policy

We may be one of the only dental clinics to offer a 100% satisfaction guarantee.

Within one year of service, if for any reason you are unhappy with your cosmetic dental work (veneers, full mouth reconstruction, etc), you can go to any other dental clinic and we will pay them or you up to what you paid us for that service. If for any reason we start treatment but can't finish (root canal gets too complicated) we will pay the specialist up to what you paid us for that procedure.

Please note, the refund is only done if you go somewhere else to have it be redone. If you are unhappy but never have it redone, there is no refund. Just like you can't go to Walmart and buy a nice tv, tell Walmart you don't like the tv but never return it. They won't refund it.

Please note risks we warn you about prior to starting procedure are not refundable (Examples - crown falls off or needing a root canal after veneers).

---------- (Initials)

Use of Insurance at The Smile Mission

I understand that the following treatments: +3 crowns, implants, bridges, dentures, braces and other complex are often denied procedures require pre-approval. The Smile Mission ESTIMATES what my insurance will pay. If my insurance pays less than the estimated amount, I MUST cover the difference.

I understand that if my insurance denies the claim and/or does not pay the bill it will be my responsibility to pay the entire bill.

I understand that fees, percentages, rules and insurances change all the time and the estimate may not be exactly correct.

---------- (Initials)

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 videos to be taken for use of dental records, research, and/or marketing purposes. We assume if you allow a recorded interview or after photos that include your face to be taken you are allowing us permission to post those photos/videos on social media.

  ---------- (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 the right to have all of 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 for 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, text messages, 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 that I always have the option to go to another dental office. Lastly, I have been informed about the 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)

- I approve x-rays to be taken for my office procedure. I understand that if I have nothing done or only a simple cleaning or whitening there will be no charge for the x-rays. If I have any other procedure done x-rays will be charged.

  ---------- (Initials)

Signature Form

- 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
  4) lying to 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.

Patient Name	Patient Signature	Date

Welcome to The Smile Mission Family

At the *The Smile Mission* we make dentistry affordable

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

Everyone 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/Delay

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

All missed or cancelled appointments (with less than 48 hours notice) will be charged $50.

All appointments exceeding the 15min waiting tolerance range will be charged $20.

I have read and accept the The Smile Mission Terms

Date: / /

Signature

info@thesmilemission.com www.thesmilemission.com