New Patient Form

Name: _____

How did 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: _____

How long did it take you to get here? ☐ Less 30 min ☐ 30min-1hr ☐ 1-2 hrs ☐ +2 hrs ☐ Flew

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

Are you interested in applying for financing? ☐ No ☐ Yes

Do you speak any other languages besides English? Spanish ☐ Creole ☐ French ☐ Portuguese ☐
Russian ☐ Vietnamese ☐ Arabic ☐ Chinese ☐ Hebrew ☐ Farsi ☐ Other _____

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.

Physician's 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 Valve 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
☐ Kidney Problems
☐ Osteoporosis
☐ 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

Any dentist require you to get clearance for any dental procedure in the past? ☐ No ☐ Yes

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

Use of Insurance at The Smile Mission

I understand that +3 crowns, implants, bridges, dentures, braces and other complex procedures the insurance often does not pay and therefore a pre-approval is required. 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

- 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)

Signature Form

- 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)

- I understand that The Smile Mission is committed to increasing access to quality dental care by providing treatment options that are more affordable than those typically offered in many dental offices. The Smile Mission's philosophy is to begin with the most conservative and cost-effective procedure and to recommend more advanced or expensive options when the most cost-effective procedure is no longer viable. Examples may include starting with a panoramic X-ray rather than a CBCT, attempting a large filling or pulp cap before recommending a root canal and crown, or attempting to save a tooth before considering an extraction and implant. I understand that conservative and lower-cost treatment options may carry an increased likelihood of requiring additional visits or future treatment if the initial approach is not successful. I acknowledge that The Smile Mission is doing its best to make dentistry more affordable while still providing care that meets accepted dental standards.

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

- The Smile Mission has developed, invented and created many 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)

- I understand to keep prices affordable at The Smile Mission – patients must be on time.
  If I do not confirm 48 hours in advance -> put on standby list = long wait lines.
  If confirm and 15 minutes late -> fee and appointment may be rescheduled.
  If confirm and miss appointment -> fee at next appointment.

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

- I understand that payment must be done before any treatment is done. I understand that if on a payment plan and payments stops -> The Smile Mission will not be able to continue treatment and cannot fix anything until payment is received.

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

Signature Form

- If The Smile Mission can not contact me, I authorize The Smile Mission to talk to my emergency contact about my dental condition, including billing, insurance, rescheduling of appointments, lab cases and dental work and dental condition. I do not have to sign this. Signing this does makes it much easier for us to communicate with patients.

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

- I understand if something breaks or needs to be fixed or any other problem – I will be expected to pay for my own travel expenses (flights/hotel/uber/car rental) and will not ask for financial compensation for days not worked. I understand that The Smile Mission will try their best but nothing is 100% guaranteed and if I need to come back – transportation cost I will need to pay.

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

- I understand that while The Smile Mission is affordable, many of its procedures, treatment steps, and systems are highly specialized. Dentists at The Smile Mission are specifically trained in these systems, especially for advanced procedures such as All-on-4, full mouth reconstruction, implants, veneers, and crown/bridge cases. I acknowledge that if complications occur, it may be unlikely that another dental office will be able to continue or complete the case, and other offices may have different treatment methods or protocols. I understand that if I begin any of the above procedures at The Smile Mission, I am responsible for completing the treatment at The Smile Mission. If complications arise, I will need to return to The Smile Mission for follow-up and completion, as most other offices may be unable to assume the case or may charge significantly higher costs to do so.

  ---------- (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