UNIVERSAL SMILES
• CARING • GENTLE • DENTISTRY • TRUSTED •

Welcome To Our Office!

Please aid us in giving you superior care by completing the necessary forms for us. If you have any questions or need assistance, please ask us we will be happy to help.

Patient Information

Patient Name: _____ Date:_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell):_____

E-Mail Address:_____ Confirm appt. by E-mail: _____Yes: ____No:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hepatitis
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Botox / Juviderm
- ☐ Snore / use C-PAP
- ☐ Sleep Apnea
- ☐ Use Oxygen tank
- ☐Other_____ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Have you ever received, or are you currently receiving, a medication known as Bisphosphonates for treatment of bone cancer or osteoporosis? (Ex: Zometa, Aredia, Fosamax, Boniva, Actonel, Didronel,Skelid)
  Yes ____ No_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

* **Please list any medications you are currently taking**_____
* Who may we thank for referring you to our office?_____
* **Person to call in case of an emergency**_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Financial Agreement

It is our policy to bill your insurance carrier as a courtesy to you. You are ultimately responsible for your account. If your insurance does not remit payment within **60 Days** the balance will be due from you immediately. Returned checks are subject to a $35 NSF fee.

Please realize that:

1. Your insurance is a contract between you and your insurance carrier.
2. Our fees are comparable to other dentists in the area. This has no relationship to what insurance companies remit for payment.
3. Not all services / procedures are covered benefits by insurance companies.

We encourage all patients to read their policies and if they do not understand please speak to your employer or insurance carries. A written treatment plan will be given to prior to any services performed, but again it is only an estimate. Your dental provider will notify you of any changes during the course of your appointment if anything changes. All estimates are based on preliminary information your insurance provider has given to us. **We must emphasize that as a dental provider, our relationship is with you not your insurance company.**

Signature:_____ Date:_____

Appointment Agreement

Your Appointment is a commitment of time between you and our office. If you find that you cannot keep your appointment, we require a minimum of 24 hours notice so that we are able to assist other patients with their dental needs. If this notice is not given a charge of $ 50 will be applied to your account. After 2 consecutive no shows; any additional appointments you may have will be cancelled. By signing below, you understand our appointment cancelation policy, and will make every attempt to give us proper notification.

Any appointments that are more than 1 hour will require a $75 per hour non- refundable deposit to secure your appointment time.

Signature: _____ Date: _____

Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Consent for Use and Disclosure of Health Information

By signing this consent, you consent our use and disclosure of your protected health information. This is used to carry out treatment, payment activities and healthcare operations. Understand that your health information may be accessed by or personnel during your care at this office. This practice is committed to protecting your privacy. We will only use your information as is necessary to properly diagnose and treat. By signing below, you acknowledge that we are allowed to communicate to other health care providers that we refer you to, pharmacists, and insurance providers in regards to your care.

My medical/ accounting information may also be discussed with:_____

Signature_____Date:_____

I grant permission to Universal Smiles Dentistry to telephone me at home or at my work to discuss matters related to this form.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Photo Release

I, _____ authorize Universal Smiles Dentistry and its affiliates to use my name, photo, video, and/or signature in all aspects of marketing, website, and office presentations.