PATIENT INFORMATION

Welcome to Smile Craft Family Dentistry. Thank you for choosing our office to assist you with your dental needs. Please fill out the information below, and don't hesitate to ask any questions.

Patient Name: _____
Last First Middle Initial (Preferred)

Birthdate: _____ Gender: ❑ M ❑ F Married: ❑ Y ❑ N SSN (optional): _____

If minor, name of legal guardian: _____ Relationship to Patient: _____

Home/Mobile/Work Phone: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Home Address: _____
Street City State Zip Code

Dental Insurance Company: _____ (If applicable) ID Number: _____

*If you have dental coverage, we will gladly help you maximize your benefits. Because insurance policies vary, estimates are provided but are not guaranteed. If any changes are made to your insurance policy, please inform us right away.

How did you hear about us?

- ❑ Person (who): _____
- ❑ Referral (from): _____
- ❑ Website/Google
- ❑ Radio
- ❑ Other (please describe): _____

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist: _____

Do you have, or have you had any of the following?
(Please check any that apply)

❑ Bad breath	❑ Grinding teeth	❑ Sensitivity to hot
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to Sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between teeth	❑ Sensitivity to cold	❑ Sores or growths in your mouth

How often do you brush?

_____

How often do you floss?

_____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe: _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates: _____

Do you smoke, vape, or use tobacco? ❑ Yes ❑ No

Women:

Are you pregnant? ❑ Yes ❑ No If yes, how many weeks? _____
Are you nursing? ❑ Yes ❑ No
Taking birth control pills or other forms of contraceptive? ❑ Yes ❑ No

Do you have, or have you had any of the following?
(Please check any that apply)

❑ Are you required to premedicate before any dental treatment?

❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Blood Disease
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory Problems
❑ Cortisone Treatments
❑ Cough, Persistent
❑ Cough up Blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ HIV/AIDS
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Skin Rash
❑ Stroke
❑ Swelling of Feet/Ankles
❑ Back Problems
❑ Thyroid Problems
❑ Tobacco Habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer
❑ Venereal Disease

❑ None of the above

❑ Other: _____

Nitrous Oxide (laughing gas): Do you require nitrous oxide (laughing gas) for each treatment appointment? Please be aware that there is no guarantee of insurance coverage for this. In this case, it will cost $50 out of pocket.

❑Yes ❑ No

By signing below, I agree that the above information is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor if I, or my minor child, has a change in health at any point.

_____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____

Print Name of Patient, Parent, Guardian, or Personal Represenative *Relationship of patient*

MEDICATIONS

List of all medications you are currently taking:

_____

_____

Pharmacy Name: _____ Phone Number: _____

ALLERGIES

- ❑ Amoxicillin/Penicillin
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Latex
- ❑ Sulfa
- ❑ Other: _____

❑ NO KNOWN ALLERGIES

By signing below, I agree that the above information is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor if I, or my minor child, has a change in health at any point.

_____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____

Print Name of Patient, Parent, Guardian, or Personal Represenative *Relationship of patient*

Patient Registration Forms

You may be asked to sign these forms electronically as well. Thank you.

FINANCIAL AGREEMENT:

* For my convenience, this office may release my information to my insurance company and receive payment directly from them. If insurance does not pay for treatment done, I am required to pay the balance off.

* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

* If sent to collections, I agree to pay all related fees and court costs.

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible for payment.

* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

* I will pay a deposit for appointments without 24 hours notice. (Please see Appointment Cancellation and No-Show Policy on the next page)

* Treatment plans may change, and I will be responsible for the work done.

PATIENT/PARENT/GUARDIAN INITIALS: _____ Date: _____

HIPAA PRIVACY:

I understand that I am giving my permission for Smile Craft Family Dentistry to use and have disclosure of my protected health information (PHI) in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission. A copy of the Notice of Privacy Practices may be provided by request.

PATIENT/PARENT/GUARDIAN INITIALS: _____ Date: _____

MEDICAL HISTORY:

I agree that all of the information I have provided regarding my medical history on the 'Patient Information' form is accurate and true to the best of my knowledge. I have also confirmed/denied any medications being taken, any allergies, and/or any medical issues/conditions.

PATIENT/PARENT/GUARDIAN INITIALS: _____ Date: _____

Appointment Cancellation and No Show Policy

We understand that emergencies happen, but when a patient does not show up or cancels without at least 24 hours' notice, we are unable to offer that time to another patient in need. Advance notice allows us to manage scheduling effectively and maintain efficient clinic operations, which is especially important for health and safety protocols. Since we provide one-on-one treatments, missed appointments create a significant inconvenience for your dentist, our office, and other patients.

We appreciate your understanding and agreement to the following policy:

Appointment Confirmation Requirement
To secure your appointment, **you must confirm at least 24 hours in advance on the business day prior to your scheduled time**. If your appointment is not confirmed, it may be reassigned to another patient. Please contact our office via phone, text, or email to confirm promptly.

Cancellation Policy

- Cancellations must be made at least 24 hours (or one business day) before the appointment.
- For Monday and Saturday appointments, cancellations must be made by Thursday at 3:00 PM, as our office is closed on Fridays.
- The scheduling parent or legal guardian of minors who fail to cancel with proper notice will be held responsible for the missed appointments.

Definition of a "No-Show" A "no-show" is defined as:

- Failure to attend a scheduled appointment.
- Canceling an appointment with less than 24 hours' notice.
- Arriving more than 15 minutes late.

By signing below, I acknowledge that I understand and agree to the policies outlined in this document.

_____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____

Print Name of Patient, Parent, Guardian, or Personal Represenative *Relationship of patient*

Appointment Cancellation and No-Show Policy

New and Established Patients:
We will send reminder phone calls and text messages at least 24 hours before your appointment. If a new patient fails to attend or cancels an initial appointment with less than 24 hours' notice, a $35 deposit will be required before rescheduling. This deposit can be applied toward a co-pay or refunded at the rescheduled appointment.

To ensure you receive important updates, please provide our staff with your most accurate contact information, including your phone number and home address. The disclosure of your personal information is at your discretion.

"Two-Strikes" No-Show Policy

- If you fail to attend your scheduled appointment without providing at least 24 hours' notice, a **$35 deposit** will be required to secure your next appointment. **This deposit will be refunded when you attend your rescheduled appointment**. Please note that deposits required under this policy are not payable by insurance companies.
- If you no-show a second time, we regret to inform you that we will no longer be able to schedule future appointments for you, and you will be **dismissed from the practice. You will need to find a new dental provider for your care.**

Courtesy and Respect for Others:

Your appointment time is reserved exclusively for you. If you cannot attend, please notify us as soon as possible so we can offer the time to another patient. Missed appointments not only prevent others from receiving needed care but also impact the efficiency of our practice.

We appreciate your understanding and cooperation in maintaining a fair and effective scheduling system. If you have any questions, please contact our office.

By signing below, I acknowledge that I understand and agree to the policies outlined in this document.

_____

Signature of Patient, Parent, Guardian, or Personal Representative *Date*

_____

Print Name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*