



PRO SMILE

WELCOME TO PRO SMILE!

We are delighted you have chosen our practice, and look forward to helping you with your dentistry for many years to come. We feel that every patient in our practice deserves to have a smile they can be proud of. We are excited to offer our patients a unique program we call
Lifetime Whitening!

When you come to our office for your initial examination and cleaning, we will provide you with custom bleaching trays and materials for \$49. Then, at each six month preventive visit, we will give you a complimentary touch up kit of whitening gel. This ensures that you will be able to keep your teeth bright and beautiful for LIFE*!

All we ask in return is:

- **You keep your six month preventive visits current.** Your long term dental health is as important to us as it is to you. Our patients have found that these six month visits help greatly reduce emergencies. That is why we are happy to provide this extra bonus for our patients who are committed to their dental health.
- **Provide at least 24 hours notice** if you need to cancel or change an appointment. In order to provide exceptional services like *Lifetime Whitening* to all of our patients, we ask that you give us the courtesy of advance notice for schedule changes.

We appreciate the opportunity to serve you, and look forward to seeing your bright smile for many years to come!

I understand the *Lifetime Whitening* program requirements, and would like to enroll.

Signed _____ Date _____

**Lifetime Whitening* membership valid for as long as Pro Smile maintains private practice in dentistry and is not transferable upon the sale of practice.

Pro Smile

PATIENT INFORMATION

PATIENT NAME _____

RESPONSIBLE PARTY _____

HOME PHONE () _____ WORK PHONE () _____

CELL PHONE () _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ SSN _____

EMPLOYER _____ OCCUPATION _____

SINGLE ___ MARRIED ___ NAME OF SPOUSE _____

EMAIL ADDRESS _____

REFERRED BY: _____

INSURANCE INFORMATION

INSURED'S NAME _____

INSURED'S SSN _____ DOB _____

INSURED'S EMPLOYER _____ WORK PHONE # _____

INSURANCE CO. _____ INSURANCE PHONE # _____

INSURANCE ADDRESS _____

GROUP # _____

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted on behalf of me and/or my dependents (i.e. personal information, x-rays, progress notes...) until I have submitted a written request disallowing this. I further agree and acknowledge that my signature on this document authorizes my signature on each and every claim to be submitted for me and/or my dependents and that this signature will bind me as though the undersigned had personally signed the particular claim. This signature will authorize the insurance company to send their payment directly to Pro Smile. I understand that even though I may have insurance coverage the contract I have is between the insurance company and me. Submission of insurance is a benefit to my family and me. Anything not paid including, but not limited to, the difference in fees between the insurance company and our office is to be paid immediately to Pro Smile.

AUTHORIZED SIGNATURE

DATE

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you / would you have any problems chewing gum? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are your teeth crowding or developing spaces? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have more than one bite and squeeze to make your teeth fit together? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you clench your teeth in the daytime or make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 28. Do your gums bleed when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 27. arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulpham | | | 32. neurologic problems (attention deficit disorder) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. venereal disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. alcohol / drug dependency _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. emphysema, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. breathing or sleep problems (i.e. snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 23. diabetes (HbA1c = _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. digestive disorders (i.e. gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

ARE YOU:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. aware of a change in your general health _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. subject to frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. a smoker or smoked previously _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES OF DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use and disclose your health information for treatment, payment or healthcare operations; you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved in Care: We may use and disclose your health information to notify, or assist in the notification of (including identifying family member, your personal representative or another person responsible for your care), your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information used on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar terms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your information when we are required to do so by law.

Uses or Neglect: We may disclose your health information appropriately if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I have received a copy of this Office's Notice of Privacy Practices

(Please Print Name)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-



Financial Guidelines

Thank you for choosing our practice for all your dental care needs. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. These financial guidelines are intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Our office is not a party to that contract.

As a courtesy to you we will help you process all your insurance claims. We will estimate your portion due at the time of service to the best of our knowledge. We will then bill your insurance and absorb any further costs by billing you, or you may provide us with credit or debit information to keep on file.

Payment is due at the time service is provided. Our office accepts cash, personal checks, Master Card, Visa, American Express, and Discover. Outside financing is available through Chase Health Advance upon request and approval.

Regarding divorce and billing problems: This office is not a party to any divorce decrees. We may bill the responsible party as a courtesy. Please understand that our legal right is to bill the party (or guardian) that is present for treatment. Any returned check and/or balances older than 60 days may be subject to collection fees.

If you have any questions regarding our financial guidelines, please ask. We are committed to providing you with the most positive experience in dental care.

Print Name

Signature

Date