Date: _____

SmileWorks
Daron Lind DDS
2320 E. Gala St., Suite 200
Meridian, ID 83642
(208) 846-8847

Welcome! We are pleased that you have chosen our office to care for your dental health. Please help us by taking a minute to provide us with a little information about yourself.

PATIENT INFORMATION

Name:_____ Preferred Name: _____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work #:_____

Email: _____

Best Contact # to confirm appointments:_____

Date of Birth:_____ Social Security No: _____ Sex: ____Male ____Female

Marital Status: Married ____ Single ____ Divorced ____ Widowed ____ Other _____

Spouse's Name: _____ Emergency Contact No.:_____

Patients' Employer: _____ Employer Phone No.:_____

Whom may we thank for referring you to us? Please check all that apply.

Physician _____ Pepper Ridge ES_____ Spalding ES_____ Website_____

Portico Pharmacy_____ Fred Meyer Pharmacy _____ Street signage _____

Other_____ Friend/Family/Patient here:_____

BILLING INFORMATION

Person Responsible for Payment: _____

Social Security No.:_____ Date of Birth: _____

Responsible Party's Address:_____

City:_____ State:_____ Zip Code:_____

Responsible Party's Home Telephone:_____ Business Telephone:_____

Responsible Party's Employer: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: _____

Address of Insurance Company:_____

Telephone Number of Insurance Company:_____

Name of Insured:_____ Date of Birth: _____

Subscriber # or Social Security # of Insured: _____ Group #: _____

SECONDARY INSURANCE INFORMATION (If applies)

Name of Insurance Company: _____Phone#_____

Address of Insurance Company:_____

Telephone Number of Insurance Company:_____

Name of Insured:_____ Date of Birth: _____

Subscriber # or Social Security # of Insured: _____ Group #: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No ❍ N/A

If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No ❍ N/A

If yes, please explain:_____

Are you taking medications, pills or drugs? ❍ Yes ❍ No ❍ N/A

If yes, please list:_____

Women: Are you ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Sulfa ❑ Metal ❑ Latex ❑ Local Anesthetics
❑ Other, please list:_____

Check if you have had any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatment
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis A, B, C
- ❑ 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 or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

DENTAL HISTORY

Reason for Today's Visit: _____

Date of last dental care:_____ Date of last X-rays: _____

Former Dentist: _____

Check if you have had problems with any of the following:

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

How often do you floss?_____ How often do you brush?_____

Patient Name:_____Date:_____

FINANCIAL POLICY

Your insurance is a contract between you, your employer, and your insurance company. Please note that you are responsible for making us aware of individuals covered by your policy, the procedures your insurance plan will cover, your deductible, the percentage covered by each procedure, and your annual maximum allowance. This information is contained in the insurance company booklet furnished to you upon enrollment for dental coverage. The type of treatment you need and receive from me is based on my professional judgment, expertise and training and your dental needs. I will not compromise what is best for my patients by diagnosing treatment needed based on an insurance company benefit plan.

Your estimated portion of the balance is due at the time of service unless prior financial arrangements have been made. While filing of insurance claims is a courtesy that we happily extend to our patients, all charges are your responsibility. There will be a finance charge on any balance outstanding 90 days after the completion of your dental treatment. This 90 day period allows time for insurance companies to respond and for us to let you know if there is any remaining balance due from you. After 90 days, any outstanding balance will be subject to a service charge of 1.75% per month (21% annually). Returned checks are subject to a $20 accounting fee.

We realize that temporary financial problems do arise, and we encourage you to contact us promptly for assistance in the management of your account. All financial arrangements must be made prior to a scheduled appointment. If no specific arrangement has been established, then full payment will be expected.

For your convenience, we accept payment by cash, check, or credit card. We accept Visa, MasterCard, and Discover. We also offer outside financing through Care Credit which give you the option of paying over 12 months with no interest.

If you have any questions about the above information, please do not hesitate to ask for our assistance. We are here to help you!

APPOINTMENTS

We value your time. We will do our best to stay on schedule so that you can be seen at your appointed time. In return, please be on time for the appointment as this time has been reserved just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us with at least **2 working days advance** notice so that we have the ability to find someone to take your place.
Keep in mind: Broken and missed appointments are costly for everyone. Initials:_____

AUTHORIZATION AND CONSENT

General Consent to Treatment: I agree and consent to a dental examination by Dr. Lind. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information: I authorize Dr. Lind to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other healthcare professionals.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Dr. Lind.

Photography Release: I authorize Dr. Lind to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

Notice of Privacy Practices I acknowledge that I have the right to read the current "Notice of Privacy Practices" and know that a copy is available for me and will be given to me upon request.

Numbness following use of anesthesia: In preparation of teeth for crowns or bridges, anesthetics are usually needed. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues that is usually temporary; in rare instances, such numbness may be permanent

_____ Date: _____

Signature of Patient, Parent or Guardian