Distinctive Smiles OF DUBLIN

Full Name _____ Today's Date _____

(circle one) Mr.Mrs.Ms.Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

Whom may we thank for referring you to our practice? _____

Home Address _____ Home Phone _____

City _____ State ____ Zip _____ Cell Phone _____

E-mail address _____

Preferred contact ❑E-mail ❑Home Phone❑Work Phone ❑Cell Phone Best time to call _____

Employer _____ Occupation _____ SS#_____

Dental Insurance ❑Yes❑No If yes, Insurance Co_____ Group #_____

Insurance Address _____ Policy Holder ID# _____

Policy Holder Name_____ Policy Holder DOB _____

Financially Responsible Party❑Self ❑Spouse ❑Parent/Guardian

Spouse / Partner _____ Cell Phone _____

Additional Emergency contact _____ Phone _____

Last dental visit _____ with Dr. _____

Why have you made this appointment _____

PLEASE SELECT ONE BOX ON EACH LINE

❑My mouth is very comfortable❑My mouth is moderately comfortable❑My mouth is uncomfortable

❑My smile is excellent❑I would like to change my smile❑I am unconcerned about my smile

❑I will do whatever I must to keep my teeth❑I want to keep my teeth but only within a certain budget of time and money

❑I've done the dentistry recommended to me❑I've NOT done dentistry recommended to me❑Never been recommended

MY DENTAL HEALTH IS❑Excellent❑Good❑Fair ❑Poor

Physician _____ Phone _____

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _____

Have you been hospitalized in the last 3 years? ❑Yes ❑No Reason _____

List medications you take - please include prescription and over-the-counter 1._____2._____3._____ 4._____
5._____6._____7._____
8._____9._____10._____

Allergies: Penicillin ____ Latex _____ Antibiotic _____ Other: _____

Do you currently or have a history of grinding/clenching your teeth? ❑Yes ❑No Wear an appliance? ❑Yes ❑No

Did you have braces? ❑Yes ❑No Do you feel you need to straighten your teeth? ❑Yes ❑No

Do you consider yourself under an abnormally high amount of stress? ❑Yes ❑No

Do you sleep well? ❑No ❑Yes Do you snore? ❑No ❑Yes History of sleep disorders? ❑No ❑Yes

Have you ever smoked or chewed tobacco? ❑No ❑ I Quit When? _____❑Yes - Still do How much? _____

Do you exercise regularly? ❑No ❑Yes If YES what do you enjoy doing _____

Do you now have or have you ever had the following?

❑YES ❑NO Severe or Frequent Headaches	❑YES ❑NO Mitral Valve Prolapse	❑YES ❑NO HIV / Aids
❑YES ❑NO Glaucoma	❑YES ❑NO High Blood Pressure	❑YES ❑NO Cold Sores/Fever Blisters
❑YES ❑NO Heart Attack	❑YES ❑NO Dementia/Alzheimers	❑YES ❑NO Tuberculosis
❑YES ❑NO Heart Murmur	❑YES ❑NO Psychiatric Problems	❑YES ❑NO Venereal Disease
❑YES ❑NO Abnormal Bleeding	❑YES ❑NO Drug / Alcohol Dependence	❑YES ❑NO Ulcers
❑YES ❑NO Hepatitis	❑YES ❑NO Epilepsy/Siezure	❑YES ❑NO Asthma
❑YES ❑NO Anemia	❑YES ❑NO Sinus Trouble	❑YES ❑NO Artificial Joint
❑YES ❑NO Chemotherapy	❑YES ❑NO Artificial Valve	❑YES ❑NO Arthritis
❑YES ❑NO Radiation Treatment	❑YES ❑NO Diabetes	

❑YES ❑NO Other _____

WOMEN Are you taking birth control pills? ❑No ❑Yes
Are you pregnant? ❑No ❑Yes - Due date _____
Are you currently nursing? ❑No ❑Yes

The information present on these pages is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I have read the above: Signature _____ Date _____

Cancellation Policy:

We ask for at least 48 business hours' notice for cancelling or rescheduling an appointment, otherwise, a $100.00 fee may be assessed to your account. All cancellation fees must be paid prior to scheduling another appointment.

Signature _____ **Date**_____

Insurance:

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available. However, the treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Your dental benefits are a contract between you, your employer, and the insurance company.

Signature _____ **Date**_____

Collections:

Payment for services rendered is due the day the services are performed. In the event that your balance becomes more than 90 days overdue, your account may be turned over to an outside collection agency. The responsible party agrees to pay interest, collection, and any legal expenses related to the collection of fees owed.

I agree to assume full financial responsibility for all services and treatment that is provided.

Signature _____ **Date**_____

Media Release

I hereby consent for Distinctive Smiles of Dublin to use, reproduce, exhibit, and/or distribute (in full or in part) any photogenic, video, film, and/or audio recordings of me or my likeness; and/or any written extract of such recordings in which I may be included, for any purpose whatsoever, in any medium now known or in the future invented.

I hereby release, discharge, and agree to hold harmless Distinctive Smiles of Dublin and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Signature _____ **Date**_____

Distinctive Smiles OF DUBLIN

OralID™ Shine Light. Save Lives.

Consent Form - Oral Cancer Screening

Our office strives to bring our patients state-of the art technology to provide the latest advancements in oral health. The Oral ID device allows us to visualize any oral mucosal abnormalities including dysplasia (pre-cancer) much sooner than can be detected with the naked eye. The procedure is quick, painless, and non-invasive. No rinses or dyes are used.

The cost of this screening is $30 and IS NOT covered by your dental benefits. Our team will continue to perform a visual oral cancer screening if you prefer not to have the Oral ID screening. However, we have incorporated this technology because we strongly believe that this type of screening is the best way to achieve the earliest type of detection.

Similar to other cancers, early detection of oral cancer is critical. Studies have shown that early detection of oral cancer with technology like the Oral ID dramatically improve the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at risk?

- Over 17 years of age
- Previous or current tobacco use
- Previous or current alcohol use
- HPV infection
- Immune system suppression

If you have any questions about risk factors, please feel free to talk with our hygiene staff. We recommend that all of our patients be screened with the Oral ID to reduce the mortality of late stage detection.

☐ Yes, I request that your staff perform an examination with the Oral ID.

Signature_____ Name_____ Date_____

☐ No, I prefer not to have this examination at this visit.

Signature _____ Name _____Date _____