Resgistration:

Whom May We Thank For Referring You?______________________________

Date:________

Patient:___________________________DOB:__________SSN:_____________M/F

Address:____

Status: S ( ) M ( ) D ( ) W( )

Responsible Party:

Name:___________________________DOB:___________SSN:_____________

Employer: _______________________Employer Address:___________________
____

Spouse:__________________________DOB:__________SSN:______________

Occupation:_____________________Employer Address:____________________
____

____
Responsible Party Signature Date Relationship

Phone Numbers:

Home:________________Work:________________Cell:______________________
Email:__________________________

In case of an emergency, contact:_________________Relationship:_______________
Home:________________Work:________________Cell:______________________

Medical Dental History Form

Name____ Address____

Phone ____________________ DOB _________________ Spouse ____

Employer _________________ Phone ________________ Occupation ____

Physician _______________________________________ Phone ____

Date of Last Physical Exam _________________________ Date of Last Dental Exam ______________________________

	Yes	No	Comments
Any breathing or respiratory problems?	☐	☐	______
Asthma?(if yes answer a,b)	☐	☐	______
(a) Are you steroid dependent?	☐	☐	______
(b) Do you use an inhaler?	☐	☐	______
Sinus Problems?	☐	☐	______
Seasonal allergies or hay fever?	☐	☐	______
Airway obstructions?	☐	☐	______
Difficulty with intubation during general anesthesia?	☐	☐	______
A smoking habit?	☐	☐	______
History of TB? (tuberculosis)	☐	☐	______
High blood pressure?	☐	☐	______
Low blood pressure?	☐	☐	______
Angina?	☐	☐	______
Heart attack?	☐	☐	______
Stroke?	☐	☐	______
Coronary Artery Disease?	☐	☐	______
Arrhythmias?	☐	☐	______
Rheumatic Fever?	☐	☐	______
Heart murmur?	☐	☐	______
Inborn heart defects?	☐	☐	______
Mitral Valve prolapsed?	☐	☐	______
Artificial Heart Valves?	☐	☐	______
Pacemaker? (if yes answer a)	☐	☐	______
(a) Should electronic devices be avoided?	☐	☐	______
Heart Surgery?	☐	☐	______
Do you require antibiotics before dental treatment?	☐	☐	______
Blood dyscrasias?	☐	☐	______
Sickle cell anemia?	☐	☐	______
Thyroid problems?	☐	☐	______
Diabetes? (if yes answer a-c)	☐	☐	______
(a) If diabetic are you on insulin?	☐	☐	______
(b) If diabetic are you well controlled	☐	☐	______
(c) If diabetic are you on oral medications?	☐	☐	______
Liver disease?	☐	☐	______
Hepatitis A?	☐	☐	______
Hepatitis B?	☐	☐	______
Hepatitis C?	☐	☐	______
Stomach or duodenal ulcer?	☐	☐	______
GERD? (Gastro Esophageal Reflux Disease)	☐	☐	______
Colitis?	☐	☐	______
Kidney Disease?	☐	☐	______
Kidney Stones?	☐	☐	______
Glaucoma?	☐	☐	______

	Yes	No	Comments
Cancer? (If yes please answer a-d)	☐	☐	
(a) What type of cancer did you have?	☐	☐	
(b) Chemotherapy?	☐	☐	
(c) Radiation?	☐	☐	
(d) Other treatment for cancer?	☐	☐	
Facial or Jaw trauma?	☐	☐	
Scoliosis?	☐	☐	
Bone, joint, or muscular problems?	☐	☐	
Artificial joints or surgically placed prosthesis?	☐	☐	
Arthritis?	☐	☐	
If yes, how long?	☐	☐	
Any problems with local anesthesia?	☐	☐	
Fainting with local anesthesia?	☐	☐	
Allergy to local anesthesia? If so, what happened?	☐	☐	
Difficulty getting numb?	☐	☐	
History of paresthesia?	☐	☐	
Neurological Disorders?	☐	☐	
Epilepsy?	☐	☐	
Mental or emotional problems?	☐	☐	
Alcohol or substance abuse?	☐	☐	

DENTAL

	Yes	No	Comments
Are you experiencing pain from your mouth at this time?	☐	☐	
Do your gums bleed? When?	☐	☐	
Have you ever had an acute sore mouth or “trench” mouth?	☐	☐	
Are you aware of a bad taste or odor in your mouth?	☐	☐	
Are you troubled with frequent “gum boils”?	☐	☐	
Cold sores?	☐	☐	
Oral Herpes?	☐	☐	
Xerostomia? (dry mouth)	☐	☐	
Did either your mother, father, brother, or sister lose all their natural teeth?	☐	☐	
Are you satisfied with the appearance of your teeth?	☐	☐	
Have you ever had a severe toothache?	☐	☐	
Are you bothered by tooth sensitivity? Hot, cold, or sweets?	☐	☐	
Does food catch between your teeth?	☐	☐	
Do tartar and stain return quickly?	☐	☐	
Do cavities develop quickly?	☐	☐	
Can you chew satisfactorily?	☐	☐	
Do you chew on both sides of your mouth?	☐	☐	
Do you have any particular mouth habits?	☐	☐	
Are you conscious of any habit with your tongue?	☐	☐	
Do you clench or grind your teeth?	☐	☐	
Do you awaken in the morning with your teeth together, Tired jaws, numb feeling in your teeth or pain in your jaw?	☐	☐	
Do your teeth come together evenly?	☐	☐	
Are you conscious of sore, loose, or shifting teeth?	☐	☐	
Are you conscious of any high or rough teeth or fillings?	☐	☐	
Do you ever have pain opening or closing your mouth?	☐	☐	
Does your jaw ever go, “out of joint?”	☐	☐	
Have you ever had any teeth removed?	☐	☐	
Did you ever have a missing tooth or teeth replaced?	☐	☐	

	Yes	No	Comments
Allergies			
Allergy to latex?	☐	☐	______
Allergy to nickel, acrylic, or other?	☐	☐	______
Allergic to any medications or foods? (if yes please list)	☐	☐	______
Female Patients Only			
Pregnant?	☐	☐	______
Taking birth control pills?	☐	☐	______
HIV Positive?	☐	☐	______
Have you had any infections in the last 2 weeks?	☐	☐	______
Do you have any medical problems not mentioned above?	☐	☐	______

Please list all prescription and non-prescription medications, and herbal products that you are presently taking:

Medication	Dosage	Frequency
______	______	______
______	______	______
______	______	______
______	______	______

Have there been any medications that you have had to stop because you experienced side effects?

______

______

______

TO BE COMPLETED BY DENTIST:
Dental Implications Regarding Medication / Dental History:

______

______

______

Do any of the above medications effect the QT interval?

______

______

Dentist's Signature ______

Patient Name (printed) ______ **Date** ______

For Use by DMD (notes)

Patient's Signature ______

Smiles By Design

Cosmetic and Family Dentistry

Jacob Turner, DMD, P.C.

100 Andrew St, Ste A-Albertville, AL 35950

Authorization for Assignment of Benefits and Submission Claims

I authorize the health care provider named above to submit claims for payment for services to the health care service plans named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges by group insurance benefits.

Insurance Plan #1: ______________________________

Insurance Plan #2: ______________________________

Insurance Plan #3: ______________________________

Authorization for Release of Health Information

I authorize the dentist or other health care provider named above to release to hospital or health care service plans, insurance companies, self-insurers or their representatives, any and all information, and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to (5) years from this date. I know that I have the right to receive a copy of this authorization if required.

____

Name of Patient

____

Signature of Patient, Parent, or Guardian

Smiles By Design: Consent for Treatment

Jacob Turner, DMD, P.C.
100 Andrew St, Suite A
Albertville, AL 35950
(256)878-9200

1) I hereby authorize doctor or designated staff to take xrays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient's name)______________________________'s dental needs

2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3) I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible risks or complications.

4) Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. Should my account become delinquent and require the services of a collection agency or attorney fee, I will be liable for all reasonable collection fees, attorney fees, and all court costs for collection.

Patient ____________________________________Date_________________
Witness ____________________________________ Date_________________
Parent or Responsible party ______________________________________
Relationship to patient ____

Smiles By Design
Cosmetic and Family Dentistry
Jacob Turner, DMD, P.C.
100 Andrew St, Suite A-Albertville, AL 35950
(256) 878-9200

Failure to Keep Reservations

Since our patients are seen on a reservation basis, our office requests at least a 24-hour notice if you will not be able to keep your reservation. If you are unable to give a 24-hour notice, please still contact as soon as possible. There is usually an "insufficient notice fee" for a missed reservation with less than a 24-hour notice. Failure to notify this office of your inability to keep a reservation can adversely affect your standing as a patient. Should you fail to keep reservations without notifying our office at least 24-hours in advance, please understand that our office will have the right to withdraw from professional attendance upon you.

Your respect for our time is greatly appreciated!
Thank you.

____

Signature (Patient/Parent/Guardian) **Date**

Cancellation /No Show/ Rescheduling Policy for Appointments

Effective January 1st, 2023 our office policy in regards to cancelling, no-showing, and rescheduling are as follows:

1. **Cancellation/ No Show Policy for Appointments**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company. Scheduled operative appointment fees will vary depending on the length of the procedure.

2. **Scheduled Appointments**

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If a patient is **15 minutes past** their scheduled time we will have to reschedule the appointment. An appointment that is being rescheduled for the 2nd time or more will be charged a twenty-five ($25) fee; this will not be covered by your insurance company.

For any appointment broken 3 times the patient-doctor (office) relationship may be terminated at the discretion of the doctor (office).

YOUR HEALTH IS OUR FIRST CONCERN AND WE BELIEVE IT TO BE IN YOUR BEST INTEREST TO COMMIT TO THE APPOINTMENTS YOU MAKE IN OUR OFFICE TO MINIMIZE YOUR DENTAL NEEDS. THEREFORE, THIS POLICY WILL BE INFORCED.

____

PATIENT SIGNATURE **DATE**