Signature Smiles
DENTISTRY INC
SONYA G. MORGAN, DDS

Please take a moment to update your information to help us ensure the quality of your care is excellent.

A. CHIEF COMPLAINT? Explain

B. DENTAL HISTORY

Frequency of visits to dentist?

Date of most recent dental x-ray/exam?

Types of care received?

History of oral-facial injuries?

Difficulties with past treatment?

Adverse reactions to local anesthetics, latex gloves, rubber dam, dental material?

C. MEDICAL HISTORY

Drug allergies or other adverse drug effects?

Medications, vitamin, dietary supplements, or special diet?

Last time examined by physician? For what purpose?

Past and present illness? History of hospitalizations?

Weight and Height

FOR FEMALES ONLY:

Do you take oral contraceptives? ☐Yes ☐No Are you pregnant? ☐Yes ☐No Change in your menstrual pattern? ☐Yes ☐No

D. FAMILY HISTORY (Diabetes, high blood pressure, heart disease seizures, bleeding problems, cancer, other)

E. SOCIAL HISTORY (tobacco, alcohol, recreational drugs, (type amount, frequency)

Have you ever or do you have any of the conditions listed?

SKIN

☐ Itching, rash ☐ Ulcers ☐ Piercing, tattoos ☐ Pigmentations ☐ Lack of loss of body hair

EXTREMITIES

☐ Varicose veins ☐ Swollen, painful joints ☐ Muscle weakness, pain ☐ Bone deformity, fractures ☐ Prosthetic joints

EYES

☐ Conjunctivitis ☐ Blurring of vision ☐ Double Vision ☐ Drooping of eyelid ☐ Glaucoma

EAR, NOSE, THROAT

☐ Earache ☐ Hearing loss ☐ Nosebleeds ☐ Sinusitis ☐ Sore throat ☐ Hoarseness

RESPIRATORY

☐ Shortness of breath ☐ Cough, blood in sputum ☐ Bronchitis, emphysema ☐ Wheezing, asthma

☐ Tuberculosis, exposure to

CARDIAC

☐ High blood pressure ☐ Low blood pressure ☐ Pain, pressure in chest ☐ Heart attack

☐ Rheumatic, scarlet fever ☐ Heart murmur ☐ Prosthetic valves/pacemaker

GASTROINTESTINAL

☐ Difficulty chewing, swallowing ☐ Eating disturbances ☐ PUD, GERD ☐ Jaundice, hepatitis ☐ Liver disease

GENITOURINARY

☐ Difficulty, pain on urination ☐ Blood in urine ☐ Excessive urination ☐ Kidney problems ☐ Sexually transmitted diseases

ENDOCRINE

☐ Thyroid trouble ☐ Weight change ☐ Diabetes ☐ Excessive thirst

HEMATOPOIETIC

☐ Easy bruising, excessive bleeding ☐ Anemia ☐ HIV infection, AIDS

☐ Leukemia, problems with immune system ☐ Spleen problems

NEUROLOGICAL

☐ Headaches ☐ Dizziness, Fainting ☐ Seizures ☐ Paresthesia, neuralgia ☐ Paralysis

PSYCHIATRIC

☐ Anxiety ☐ Depression ☐ Other

GROWTH OR TUMOR

☐ Surgery ☐ Radiotherapy ☐ Chemotherapy

List all medications:

Drug allergies or other adverse drug effects

I certify that any and all questions I had about inquires above have been answered to my satisfaction. I was asked all these questions on this form and I have answered these questions truthfully and completely. I will not hold the staff or Doctor responsible for any errors or commissions that I may have made.

Please Print Name: _____

OFFICE POLICY

PAYMENT is required at the time any services are provided. Our office does not provide any type of payment plan. Patients may pay by cash, check, VISA, MASTERCARD or DISCOVER. If some type of extended financial arrangement is needed, this will need to be discussed PRIOR to the start of any treatment. Third party financing options are available. It is customary and required that we receive 24 hours notice if you are unable to keep your reserved appointment time. Any missed appointments without a 24-hour notice will be subject to a $50 FEE PER HOUR OF SCHEDULED TIME MISSED.

☐ I have read the above conditions regarding the office policy of this dental office and agree to their content.

Consent for Use and Disclosure of Health Information

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices.

Relationship to Patient:

☐ By checking this box, I give consent for use and disclosure of health information.

Acknowledgement of receipt of notice of privacy practice

☐ By checking this box, I acknowledge receiving a copy of this office's Notice of Privacy Practices.

Insurance

Our office is pleased that you have dental insurance to help you cover your dental expensed. As a courtesy to our patients, we will be happy to file your dental insurance for you. Please understand that we do not work for the insurance companies. We work 100% for you. The patient will pay the co-payment (the amount not covered by the insurance company) at the time any services are provided. Patient must understand that the amount that they are asked to pay is just an ESTIMATE. If an insurance payment is not received within 60 days, we may request the patient to pay the balance due, and they can seek reimbursement from the insurance company. We will provide you with any information that is required such as x-rays or written reports. We will perform our routine insurance billing procedures upon verification of coverage.

☐ I have read the above conditions of treatment and payment and agree to their content.

Patient Signature: _____