



**WELCOME TO OUR PRACTICE**

**PATIENT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Sex: \_\_\_\_\_ Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
 In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

(If parent or guardian) Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Sex: \_\_\_\_\_ Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**REFERRAL SOURCES**

Please let us know who referred you to us or how you heard about our practice: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Name of Insured Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
 Insurance Carrier \_\_\_\_\_ Phone # \_\_\_\_\_ Group # \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Name of Insured Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
 Insurance Carrier \_\_\_\_\_ Phone # \_\_\_\_\_ Group # \_\_\_\_\_

**MINOR/CHILD CONSENT**

I, being the parent or guardian of \_\_\_\_\_ (Name of Minor/Child) do hereby request and authorize the dental staff to perform necessary services for my child, including but not limited to X-rays, and an administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

**Patient, Parent or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (Must be 18 years or older to sign)

**STAFF USE ONLY**

ID#/Type	State	Exp. Date	All information has been entered into computer and scanned: Initials _____
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## DENTAL HISTORY AND CONCERNS

VivaSmiles focuses on providing comprehensive care to adults and their families. We are able to deliver care that not only improves our patient's health and aesthetics but also changes their lives. We are one of the few practices in the Midwest with specialized training in Cosmetic Dentistry and Neuromuscular Dentistry at the premier LVI Global. Neuromuscular dentists can realign your bite and treat TMJ or headache problems. We look beyond just the teeth and gums, treating the whole patient, comprehensively. We seek to establish a harmonious relationship of the three main factors affecting your bite—teeth, muscles, and jaw joints. An optimal bite is also essential to ensure that smile makeovers and dental restorations are beautiful, functional, and long-lasting.

What is your chief complaint? \_\_\_\_\_

Does floss shred when you use it? Yes No      Does food pack or catch between your teeth? Yes No

Do you smoke or chew tobacco? Yes No      Do your gums bleed? Yes No      Does your breath concern you? Yes No

Have you been instructed regarding proper home care? Yes No

Have you had braces or other orthodontic treatment? Yes No      Name of Orthodontist \_\_\_\_\_

Have you had any cosmetic procedures? Yes No      If so, please list \_\_\_\_\_

When was your last dental appointment and cleaning? \_\_\_\_\_

How healthy do you want us to get your mouth?

Basic/Average

Above average

The best it can be

Should you need treatment, at what point should we address it?

When my tooth hurts or breaks

When something is worsening

Before problem occurs

What quality of dentistry do you want us to recommend?

Basic/Average

Above average

Ideal/the best

We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?

As a general dentist

As a cosmetic dentist

As a Neuromuscular dentist

Please indicate if you have any of the following concerns (check all that apply):

My teeth are not in alignment

I have spaces I don't like

I do not like the color of my teeth

Chipped Teeth

Protruding teeth

Hidden or missing teeth

Old Fillings, Veneers, or Crowns

TMJ Disorder

I am unhappy with my facial profile

My chin is too large or small

Overall appearance of my smile

Has the fear of discomfort kept you from regular dental visits? Yes No

Are you interested in minimal sedation or nitrous? Yes No

What is the reason for trying a new dental office? \_\_\_\_\_

Are there any additional concerns you would like us to know? \_\_\_\_\_

# MEDICAL HISTORY

Although as dentists we treat the area in and around the mouth, it is a part of your entire body. Medical health problems that you may have, or medications that you may be taking, could be important to your dental health. Thank you for **thoroughly** answering the following questions.

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage \_\_\_\_\_

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so, please list (e.g. Latex, penicillin, iodine) \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? Yes No

If so, for what? \_\_\_\_\_

Have you ever had heart surgery, heart valve or joint replacement, or organ transplant? Yes No

If so, for what and when? \_\_\_\_\_

Do you require premedication (e.g. knee replacement)? Yes No If so, for what? \_\_\_\_\_

Do you or have you **ever** taken Fosamax or any other bisphosphonate, Zometa, Aredia, Boniva, or Actonel? Yes No

Women: Are you  Pregnant?  Nursing?  Taking Birth Control Pills?

Have you seen an ENT (ear, nose, and throat doctor)? Yes No Name \_\_\_\_\_

Have you seen a neurologist? Yes No Name \_\_\_\_\_

Indicate which of the following you **have ever had, or have at present**. Circle "yes" or "no" to each item.

Heart Concerns	Yes No	Neurological Disorders	Yes No	Headaches	Yes No
Congenital Heart Disease	Yes No	Osteoporosis	Yes No	Neck Ache	Yes No
Heart Murmur	Yes No	Liver Disease/jaundice	Yes No	Ringing/Congested Ears	Yes No
High Blood Pressure	Yes No	Sickle Cell Disease	Yes No	Facial Pain	Yes No
Mitral Valve Prolapse	Yes No	Asthma	Yes No	Sensitive Teeth (Hot/cold)	Yes No
Artificial Heart Valve	Yes No	AIDS/HIV	Yes No	Difficulty Swallowing	Yes No
Pacemaker	Yes No	Stroke	Yes No	Tingling in arms/fingers	Yes No
Latex Allergy	Yes No	Angina	Yes No	Jaw Clicking/Popping	Yes No
Artificial Joints	Yes No	Anemia	Yes No	Dizziness	Yes No
Kidney Trouble	Yes No	Ulcers	Yes No	Posture Problems	Yes No
Radiation/Chemotherapy	Yes No	Tuberculosis	Yes No	Trigeminal Neuralgia	Yes No
Epilepsy/Seizures	Yes No	Arthritis	Yes No	Bell's Palsy	Yes No
Hepatitis	Yes No	Difficulty Chewing	Yes No	Jaw Pain	Yes No
Psychiatric Disorders	Yes No	Insomnia/Nervousness	Yes No	Limited Mouth Opening	Yes No
Diabetes	Yes No	Teeth Clenching/Grinding	Yes No	Loose Teeth	Yes No
Thyroid Disorder	Yes No	Snoring/Sleep Apnea	Yes No		

Notes/Any other health issues \_\_\_\_\_

Medical updates \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify VivaSmiles doctors of any change in any health or medication.

**Patient, Parent or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## FINANCIAL POLICY / PAYMENT OPTIONS

Our mission is to deliver the best and most comprehensive dental care, and financial considerations should not be an obstacle in fulfilling your needs. Therefore we provide a range of payment options for our patients.

**WE ACCEPT CHECK, DEBIT CARD, VISA, MASTERCARD, DISCOVER CARD, OR AMERICAN EXPRESS**

### INSURANCE PLANS

We accept most dental plans and we will work to maximize your dental benefits and submit your insurance claims at no charge. For your convenience, we accept the insurance benefit directly from your insurance company, and only the estimated portion not covered by your insurance is due at the time treatment is performed. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion.

**Assignment and Release:** You, the undersigned, assign directly to VivaSmiles all benefits, if any, otherwise payable to you for services rendered. You hereby authorize the doctor to release all information necessary to secure the payment of benefits. You authorize the use of your signature on all your insurance submissions whether manual or electronic.

### FINANCING OPTIONS

Your health starts with a smile you're proud to show off. We are partnered with ChaseHealthAdvance, offering no interest and extended payment plans, making it easier to get the smile you've always dreamed about. Highlights include no-interest financing for up to 24 months, extended financing up to 48 months, revolving lines of credit starting at \$5,000 and no application fees. Ask your treatment coordinator about financing with ChaseHealthAdvance.

### FLEXIBLE SPENDING ACCOUNTS

If you work for a company that provides a flexible spending account, or a "flex-plan," we will explain to you the mechanism for saving up to 35% on your treatment cost by paying with non-taxable income.

### PLEASE NOTE

We require payment or a financial arrangement before the start of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For your protection, and to constantly improve the quality of care we deliver, phone calls to our office may be recorded.

A late charge of \$5.00 or 1.5% per month will be applied to unpaid balances. There will be a \$25 charge for all returned checks.

I have read the Financial Policy in its entirety and I understand and agree to all its terms.

**Patient, Parent or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Must be 18 years or older to sign)

## NOTICE OF PRIVACY PRACTICES

**Release of information:**

I acknowledge that there are instances when VivaSmiles must release information concerning my care, including copies of my medical/dental records, to certain individuals who are involved in my care, payment for my care, and other activities related to my care. Such disclosures are more fully described in NOTICE OF PRIVACY PRACTICES; and include disclosures to:

- a. Any health professionals involved in my care for the purpose of facilitating the continuity of my dental care.
- b. Any person or entity responsible for, or any person or entity acting as agent for the party responsible for payment, including 3<sup>rd</sup> party payers, self-insurers, worker's compensation carriers and governmental agencies, payment for the dental services rendered to me at this practice by their employees or any person providing services at this practice.
- c. Any federal, state or other governmental or quasi-governmental agencies of other such parties as required by law for purposes of reporting.
- d. Any continuing care, residential, or long-term care facility, or home health agency for the purpose of providing services for my care.

I acknowledge that my medical/dental information may include information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions, Human Immunodeficiency Virus (HIV) and/or Acquired Immunodeficiency Syndrome (AIDS).

I hereby give my permission for the use of photographs and x-rays made in the process of examination, treatment, and retention for purposes of consultations, research, education, or publication.

If I was referred by a medical practitioner, I hereby give my permission that any and all relevant medical data including but not limited to case notes be reported to the practitioner.

I acknowledge that I have read this form and understand its contents fully and have received a copy of the NOTICE OF PRIVACY PRACTICES. I agree to follow the rules and regulations of this practice, and understand that these rules and regulations apply not only to patients of this practice, but to the patient's visitors as well

**Patient, Parent or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## LATE/CANCELLATION POLICY

The Doctors and Team at VivaSmiles would like to ask for your cooperation in helping us better serve you. The scheduling of your appointment deserves a designated time that needs to be followed by our team and our patients. Being on time is essential for your appointment. If your arrival is more than 15 minutes late, we will evaluate what can be accomplished in the allowed time left of the appointment. More than two missed appointments without a 48-hour notice will result in a fee of \$50.

Thank you for committing to VivaSmiles so that we can provide the best care to our patients.

**Patient, Parent or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_