HEALTHY SMILES DENTAL

MATTHEW T. KINGSTON, DMD

Health History Information

Patient Information

Date_____
Patient Name_____ Preferred Name_____
Address _____
City_____ State_____ Zip_____
Home _____ Cell_____ Work_____
Please circle best phone number to reach you: HOME CELL WORK
Email_____
Date of Birth_____ Social Security Number_____
Emergency Contact_____
Phone_____ Relationship to Patient_____
How did you hear about our office?_____

Financial Information

Responsible Party Information, if other than patient

Name_____ Relationship to Patient_____
Social Security Number_____ Date of Birth_____
Address _____
City _____ State _____ Zip_____
Home Phone_____ Work Phone _____
Cell Phone_ _____ Email_____

Dental Insurance Information

Primary:
Name of Insured_____ Relationship to patient_____
Insured's Date of Birth_____Insured's ID #_____ Insured's SS#_____
Insured's Employer_____ Location_____
Insurance Company _____ Group #_____
Claims Address_____

Secondary:
Name of Insured_____ Relationship to patient_____
Insured's Date of Birth_____ Insured's ID #_____
Insured's Employer _____ Location_____
Insurance Company_____ Group #_____
Claims Address_____

I hereby authorize and direct payment of the dental benefits, otherwise payable to me, directly to the dentist or dental entity.
I understand that any remaining portion that is not paid by my insurance company will be my responsibility.

X_____ _____
Patient Signature/ Subscriber Date

As a courtesy to our patients with dental insurance, we will file all dental claims

Medical History Information

General Medical Information:

Please rate your health. Excellent Very Good Good Fair Poor

Has there been a change in your general health in the past year? Yes No

Your Physician: _____City_____ Phone No: _____

Your Pharmacy:_____City_____Phone No:_____

Specialist:_____City_____Phone No:_____
Date of last physical examination: Month _____Year _____
Current height_____ weight_____
Currently under treatment by a physician? Yes No
Please explain_____
Do you engage in regular exercise? Yes No
Type_____
Do you need to take antibiotics prior to receiving dental or surgical care? Yes No Don't know
Name of antibiotic:_____

Major hospitalizations, surgeries, and blood transfusion:

DATE (Month/Year) *REASON*
_____
_____

Allergic or unusual reaction to any of the following?

__Penicillin __Opiates/Codeine __Sulfites Other Drugs: (List) Other Substances (food, Metals, etc)
__Sulfa Drugs __Latex __Amoxicillin _____ _____
__ Asprin __Epinephrine __Clindamycin _____ _____
Type of Reaction_____
Have you ever felt your heart beating rapidly after a dental injections?_____

Women Only:

Are you PREGNANT? ____ weeks? Trying to become pregnant?__ Not sure if you are pregnant? __

Using birth control pills___ Going through menopause?__ Post-menopausal?___

Consumption of Beverages and other substances: PLEASE CIRCLE ANSWER

Number of caffeinated beverages you drink in a day:
0 1-2 3-5 5+
Number of alcoholic beverages you drink in a week:
0 1-2 3-5 5 6-10 10+
Number of Carbonated beverages a day:
0 1-2 3-5 5+
Currently using any street or recreational drugs?
__ No ___Yes (Type?)_____

Have you ever used tobacco? __No __Yes
If yes, what type:
Cigarette___ Pipe/Cigar___ Smokeless___
Do you currently use tobacco? __No ___Yes
If yes, average number of uses per day:_____
For how many years? _____

Please CIRCLE any conditions that apply and also DATE/YEAR of diagnosis:

Arthritis
Artificial Joint/Joint replacement
******Require premed_____*
******Year_____*
Asthma
******Do you carry an inhaler____*
Autism/ Asperger's
Back and/or Neck Fusion
Blood Disease
Cancer
Type:_____
year:_____
Chemotherapy *year*:_____
Chronic dry mouth
C.O.P.D (*bronchodilator/steroid*)
Diabetes I or II
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Fainting or Dizziness
Fibromyalgia
Glaucoma
Heart Disease *year:_____*
Heart Attack *year*:_____
***** *Do you carry nitroglycerin___*
Heart Murmur
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney Disease
Liver Disease
Mental Disorder
Multiple Sclerosis
Respiratory Problems
Rheumatism
Sexually Transmitted Disease
Sinus Problems
Stroke
Thyroid Disease
Tuberculosis (TB)
Other Conditions:
_____
_____

Please list ALL of the medications you take: ***(Including prescription, over-the-counter, vitamins or supplements)***

Name of Medication	Dosage	Frequency	Reason

Dental related questions:

Date of Last Dental Visit:_____ Name of Previous Dentist:_____

Are you having any tooth pain now?	Yes	No
Do you feel nervous about having dental treatment completed?	Yes	No
Are you aware of grinding or clenching your teeth?	Yes	No
Do you wear any dental appliances?	Yes	No
Is it ever difficult to open or close your mouth?	Yes	No
Do you suffer from frequent headaches or migraines?	Yes	No
Do your gums ever bleed when you brush or floss?	Yes	No
Do you suffer from chronic dry mouth?	Yes	No
Have you ever been told you snore?	Yes	No
Do you suffer from sleep apnea?	Yes	No
Do you use a C-Pap machine?	Yes	No
Have you ever suffered with a cold sore?	Yes	No

If yes, please list what triggers them for you_____

Is there anything you would change about your smile?

_____

X_____ _____

Patient Signature *Date*

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health or medications, I will inform Dr. Kingston at my next appointment without fail.

Acknowledgment of Receipt of Notice of Privacy Practices: Healthy Smiles Dental, LLC

____ I have received this office's Notice of Privacy Practices, which explains how my dental information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Privacy Questionnaire:

1. **Please list the family members or other persons, if any, whom we may inform about your general medical/dental condition and diagnosis (including treatment, payment and health care operations).**

_____ _____
_____ _____
(Name and Relationship)

2. **Can confidential messages (e.g., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No**

_____ _____ _____
Patient/Guardian Signature **Print Patient Name/Guardian** **Date**

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health.

Payment Options Include:

- Cash, Check, American Express, Discover, Mastercard, Visa (*Additional fee $35.00 will be applied for returned checks*.)
- CareCredit – interest free up to 6 months over $200 (cannot be used with any other discount or offer)

Courtesy Adjustments will be offered as follows:

- 5% discount for cash or check payments ***at the time of service*** (apply to non-insured patients only)
- 10% senior citizen discount for cash or check payments – 62/older (apply to non-insured patients only)

*****Courtesy adjustments will not be automatically applied and cannot be made retroactive*****
*****One adjustment type per visit. Courtesy adjustments will not be combined with Care credit*****

Consent for treatment: I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Do you have insurance?

• As a courtesy to you, we will help you process all of your dental insurance claims. ***Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated***. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to several reasons, specifically related to your plan.

• All charges you incur are your responsibility, regardless of your insurance coverage. ***We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.*** Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

• Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

• We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.

• Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment (s) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients***, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments.*** We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment***. We reserve the right to charge a $50 fee for multiple missed, short notice or cancelled appointments***. Multiple failed appointments may result in being dismissed from the dental practice.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. Our office may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient /Parent name printed_____

Patient /Parent signature_____ **Date**_____

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Records Request

I _____, DOB_____, hereby authorize you to release any and all dental records for services that were rendered by you or under your supervision.

Practice Name:_____
Street Address:_____
City, State, Zip:_____
Practice Phone Number:_____

Please release my x-rays/records to: _Healthy Smiles Dental_____

_____
Patient Signature Date

Family Member(s)

_____
Name Date of Birth

_____
Name Date of Birth

_____
Name Date of Birth

_____
Name Date of Birth

Please send to:

Healthy Smiles Dental
144 S. Centerville Road
Lancaster, PA 17603
Office: (717) 945-7440
Fax: (717) 431-9731

Email: office@healthysmilesdentalpa.com