Welcome!

Thank you for choosing LifeSmile Dental Care. Please complete this form. If you have any questions we will be glad to help. (Please print)

PATIENT INFORMATION

Date:_____ Name_____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Other: ____
First MI Last

Address _____ DOB: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Home #(____)_____

Employer _____ Work #(___)_____Cell #(____)_____

SSN#: _____-_____-_____ E-mail:_____@_____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Spouse's Name:_____

Spouse's Employer: _____ Spouse's Contact # (____)_____ [ ] Cell [ ] Work

Responsible Party (if different than patient)

Name _____
First MI Last

Address _____

City _____State _____ Zip _____

Contact#(___)_____ [ ] Cell [ ] Home

DOB ___/___/_____ SSN# _____

Relationship: _____

About LifeSmile Dental Care:

Since 1982, LifeSmile Dental Care has been providing exceptional dental care for patients in the St. Louis area. Based on a deep, personal belief in the importance of each patient's dental health, our office pledges to provide the best dental care in a compassionate and friendly environment.

Our services include: general dentistry, cosmetic dentistry, Invisalign, implant restorations, same day crowns, teeth whitening and much more!

PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at: [ ] Home [ ] Cell [ ] Work
Whom may we thank for referring you: _____
How do you wish to be addressed by our staff: _____

INSURANCE INFORMATION

MEDIAL INSURANCE:

Subscriber's Name _____ DOB____/____/_____ Relationship to Patient _____

SSN# or ID#_____Insurance Company_____ Policy #_____ Group #_____

DENTAL INSURANCE:

Subscriber's Name _____ DOB____/____/_____ Relationship to Patient _____

SSN# or ID#_____Insurance Company_____ Policy #_____ Group #_____

Employer: _____ Employer Contact# (____)_____Effect. Date___/___/_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No *If yes, please complete the following:*

Subscriber's Name _____ DOB____/____/_____ Relationship to Patient _____

SSN# or ID#_____Insurance Company_____ Policy #_____ Group #_____

Employer: _____ Employer Contact# (____)_____Effect. Date___/___/_____

CONFIDENTIAL

MEDICAL HISTORY & CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

ALLERGIES

Aspirin	Y	N
Barbiturates	Y	N
Codeine	Y	N
Erythromycin	Y	N
Jewelry	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Sedatives	Y	N
Sulpha	Y	N
Other	Y	N

List any other known Allergies:

_____

_____

_____

_____

CARDIOVASCULAR

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain	Y	N
Congenital Heart Defect	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Heart Surgery	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N

ENDOCRINE

Diabetes	Y	N
Thyroid Problems	Y	N

EYES, EARS, NOSE & THROAT

Difficulty Swallowing	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillitis/Tonsillectomy	Y	N

GASTROINTESTINAL

Acid Reflux	Y	N
Ulcers	Y	N

GENERAL

Anemia	Y	N
Arthritis	Y	N
Cancer	Y	N
Colitis	Y	N
Fatigue/Tired	Y	N
Headaches (severe)	Y	N
Herpes/Fever Blisters	Y	N
HIV/AIDS	Y	N
Kidney Disease	Y	N
Knee/Hip Replacement	Y	N
Liver Problems	Y	N
Lupus	Y	N
Nursing	Y	N
Pregnant	Y	N
Recent Trauma/Injury	Y	N
Rheumatic/Scarlet Fever	Y	N
Radiation Treatment	Y	N
Shingles	Y	N
Venereal Disease	Y	N
Weight Change	Y	N

HEMATOLOGICAL

Bleeding Problems	Y	N
Blood Transfusion	Y	N
Hepatitis	Y	N
Hemophilia	Y	N
Blood Thinners	Y	N

ORAL/DENTAL

Bleeding Gums	Y	N
Dry Mouth	Y	N
Jaw Problems (TMJ)	Y	N
Clicking	Y	N
Pain	Y	N
Difficulty Swallowing	Y	N
Difficulty Chewing	Y	N
Ortho/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth Clenching	Y	N
Teeth Grinding	Y	N
Tooth Pain	Y	N
Wisdom Teeth Extraction	Y	N
Do you take antibiotics before dental procedures?	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Fibromyalgia	Y	N
Osteoporosis/Bisphosphonate Use	Y	N

NEUROLOGICAL

Alzheimer's Disease	Y	N
Dizziness/Fainting	Y	N
Epilepsy	Y	N
Memory Loss	Y	N
Multiple Sclerosis	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N

PSYCHIATRIC

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating Disorder	Y	N

RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Breathing Problems	Y	N
Chest Pressure	Y	N
Emphysema	Y	N
Persistent Cough	Y	N
Tuberculosis	Y	N

SLEEP

Daytime Sleepiness	Y	N
Morning Headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
Has anyone told you that you snore?	Y	N

SOCIAL HISTORY

Do you smoke?	Y	N
Do you use smokeless tobacco?	Y	N
Do you consume alcoholic beverage?	Y	N

____ Drinks per day/week/month

Do you use recreational drugs?	Y	N

_____

Doctor Signature ***Date***

What is the reason for your dental visit today? _____

Previous/Present Dentist Name_____ Office Location _____

Office #: _____Date of last dental exam: _____ Date of last dental x-rays:_____

Are you happy with the way your smile looks? [ ] Yes [ ] No If not, what would you change? _____

CONFIDENTIAL

MEDICAL HISTORY & CONSENT CONTINUED

MEDICATIONS [ ] No [ ] Yes (If yes, please list)

MEDICATION	TAKING FOR:	TIMES PER DAY

Primary Physician Name: _____ Physician's Phone # (_____)_____

Are you under the care of other physicians? If so, please list:

Physician Name *Phone #* *Reason*

_____

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: I authorize the staff of LifeSmile Dental Care to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize the staff to perform any and all forms of treatment, medication, and therapy that may be necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by the doctor. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I am aware that information provided by my insurance company is not a guarantee of payment, only an estimate. I understand that the person who brings a minor to their appointment is solely responsible for any and all charges incurred at the time of service. I agree to promptly pay any amount due within 45 days from the date of service. I further consent to and agree to pay a late fee charge per month, minimum of $20 or maximum of $75, for any balance over 45 days. I acknowledge that I am responsible for all fees necessary to collect my account balance. I authorize the staff of LifeSmile Dental Care to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle necessary claim appeal(s).

BROKEN APPOINTMENT POLICY: We understand that circumstances can change and you might not always be able to keep an appointment time that has been reserved for you. We simply ask that you notify the office 24 hours in advance to cancel or reschedule your appointment. Failure to do so will result in a DISMISSAL from the office after 3 broken appointments. In most cases, one of our staff will also call you the day before your appointment to remind you and confirm your appointment. However, this is done only on a "time permits" basis and we cannot guarantee that a courtesy reminder call will always be made. Thank your for your understanding and cooperation.

Consent (adult):

Name of Patient _____ _____ Date _____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ Date _____

Signature of Parent/Guardian

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI.

I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ Date _____

[ ] I received a copy of the Privacy Practice Notice. Signature of Patient/Responsible Party