SMILE SAVERS
MOBILE DENTAL HEALTH SERVICE
514 Edwin Avenue
Kalamazoo,MI 49048

# PATIENT REGISTRATION FORM
## 18 and up

First Name_____

Last Name_____

Birthdate_____

Address_____

_____

Phone_____

Email_____

Emergency Contact Person_____
Phone_____

Insurance(Medicaid#)_____
Obtaining services from Smile Savers may result in duplicate services which can effect benefits from other dental insurance you receive.

Do you smoke? NO__ YES__

Hip/Knee replacement? NO__ YES__

When was your last dental cleaning?_____

_____ _____
(Patient Signature) (Date)

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# DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

| | | | |
|---|---|---|---|
| ❑ Discomfort, clicking or popping in jaw | ❑ Lost/Broken Filling(s) | ❑ Stained teeth | ❑ Broken/Chipped tooth |
| ❑ Blisters/Sores in or around the mouth | ❑ Teeth grinding | ❑ Locking Jaw | ❑ Sensitive tooth, teeth or gums |
| ❑ Red, swollen or bleeding gums | ❑ Ringing in Ears | ❑ Bad breath | ❑ Active Decay/Cavity(ies) |

❑ Other:_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist:_____ (____) _____
Name Address Phone#

Last Dental exam:____/____/____ Last Dental X-rays:____/____/____ Last Dental Cleaning:____/____/____

Have you had problems with previous dental treatment? If so, explain:_____

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from (EXCELLENT=10) 1-10:_____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile?_____

# MEDICAL HISTORY & INFORMATION

**What medications are you taking?** ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ Vitamins/Supplements _____
❑ Other(s), please list:_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

| | | | | |
|---|---|---|---|---|
| Y N Heart Murmur | Y N Heart Attack/Stroke | Y N Heart Surg./Pacemaker | Y N Heart Disease/Angina | Y N Shingles |
| Y N Lung Disease | Y N Thyroid Problems | Y N Congenital Heart Defect | Y N Cancer/Tumor(s)/Growth(s) | Y N Hepatitis |
| Y N Liver Problems | Y N Seizures/Epilepsy | Y N Artificial Heart Valves | Y N Chemotherapy/Radiation | Y N Glaucoma |
| Y N Blood Disease | Y N Venereal Disease | Y N Mitral Valve Prolapse | Y N X-ray or Cobalt Treatment | Y N Arthritis/Gout |
| Y N Kidney Problems | Y N Cosmetic Surgery | Y N G.I. Problems/Ulcers | Y N Frequent Thirst/Urination | Y N Leukemia |
| Y N Scarlet Fever | Y N Dizziness/Fainting | Y N Emphysema/Asthma | Y N Bleeding Problems/Anemia | Y N Chest Pains |
| Y N Tuberculosis TB | Y N Cold/Fever Blisters | Y N Diabetes/Hypoglycemia | Y N High/Low Blood Pressure | Y N Bruise Easily |
| Y N HIV+/AIDS/ARC | Y N Blood Transfusion | Y N Psychiatric Problems | Y N Artificial Bones/Joints/Implants | Y N Allergies |
| Y N Rheumatic Fever | Y N Alcohol/Drug Abuse | Y N Back/Neck Problems | Y N Severe/Frequent Headaches | Y N Nervousness |
| Y N Sinus Problems | Y N Eating Disorder | Y N Respiratory Problems | Y N Jaw Problems TMJ/TMD | Y N Sleep Apnea |

Please list any other surgeries or medical conditions you have or ever had:_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine
❑ Dental Anesthetics ❑ Foods:_____ ❑ Others:_____

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

Please rate your general health from 1-10:_____ Do you wear contact lenses? ❑ Yes ❑ No

**For women:** Are you taking Birth Control pills? ❑ Yes ❑ No Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long?_____ Are you nursing? ❑ Y ❑ N How many children have you had?_____

❑ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

❑ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

❑ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❑ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature _____ Date____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

**UPDATE** (OFFICE USE)

Initials ____ Date ____/____/____
Comments _____

Initials ____ Date ____/____/____
Comments _____

Initials ____ Date ____/____/____
Comments _____

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**514 EDWIN AVENUE**

**KALAMAZOO, MI 49048**

# HIPAA RELEASE OF INFORMATION

# AUTHORIZATION FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment, includes direct and indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (my insurance company)

I have also been informed of and given the right to review and secure a copy of Smile Savers Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Smile Savers reserves the right to change the terms of this notice and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosures that occurred prior to the date I revoke this consent is not affected.

Printed Name_____

Signature_____

Relationship to patient_____

Date_____