AMAZING SMILES
Dentistry

Patient Intake Information

Patient Information

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Home □ Cell Alt Phone: _____

Email: _____ Primary Language: □ English □ Spanish □ Other: _____

Emergency Contact: _____
Name Relationship Phone

What is the reason for your visit / Chief Complaints? _____

_____

How did you hear about us? _____

Primary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Social Security: _____

Patient Relationship to Subscriber: _____

Secondary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr Caceres insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative

Name of Patient, Parent, Guardian, or Personal Representative (Print)

_____ _____
Date

Relationship to Patient

AMAZING SMILES Dentistry

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

AMAZING SMILES
Dentistry

DENTAL HISTORY

Patient Name: _____ Date: _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to replace your silver fillings?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment?	Yes	No
Please describe _____		
Have you ever had an upsetting dental experience?	Yes	No
Please describe _____		
Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

AMAZING SMILES

Informed Consent to Treatment

Drugs and Medication
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
(Initial: _____)

Changes in Treatment Plan
I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed.
(Initial: _____)

X-Rays
I understand x-rays are necessary for proper diagnosis and treatment.
(Initial: _____)

Fillings
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage.
I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common effect after a newly placed filling.
(Initial: _____)

Local Anesthetic
Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment. (Initial: _____)

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I consent to the proposed treatment.
(Initial: _____)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
3. In general terms, the dental procedure(s) can include is not limited to:
    a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride
    b. Application of resin "sealants" to the grooves of the teeth
    c. Treatment of diseased or injured teeth with dental restorations (fillings).
    d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections
4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.
5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.
7. **I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.**

_____
Patient Name (Print)

_____
Patient or Parent | Guardian Signature

_____
Date

AMAZING SMILES

Acknowledgement of Privacy Practices

ACKNOWLEDGEMENT FORM

I have received the "**Notice of Privacy Practices**" and have been provided an opportunity to review it.

Patient Name (Print) _____ Patient Date of Birth _____

Parent | Guardian Name if Patient is a Minor (Print) _____ Relationship to Patient _____

Signature _____ Date _____

Patient Consent to receive Mail, E-mail and/or Telephone Messages

Please Print (Last Name) _____ (First Name) _____ (M.I) _____

I agree that the practice may communicate with me electronically at the following address:

E-mail Address (please print) _____

Do we have your permission to:

Send a recall appointment reminder to your home? **Y __ N __**

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: **Y __ N __**

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

Patient/Legal Guardian Signature _____ Date _____

If signed by other than patient, specify relationship to patient: _____

AMAZING SMILES
DENTISTRY

Financial Policy

Thank you for choosing Amazing Smiles Dentistry to serve your dental needs. Please take the time to read the following: Please initial each section and sign and date the bottom of the form.

_____ Full payment is due at the time of service, unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances not paid by the insurance is the patient's responsibility. Insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statement and follow up with your insurance carrier to ensure prompt payment.

_____ **If any patients portion due at the time of service is not paid, a $50.00 administrative fee will be charged to your account.**

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointment at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to appear for your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-sufficient Funds (NSF). If an NSF check is received, we will no longer be able to accept checks as a method of payment on your account.

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month or 18% APR.
Collection fees (up to 42% of the full balance)
Legal fees for collection services.

_____ Treatment plans are only an estimate, and the patient is responsible for any fee differences.

X _____
Patient/Legal Guardian Signature

X _____
Date

X _____
Print Name

X _____
Witnessed By

AMAZING SMILES
Dentistry

Appointment Cancellation and No-Show Policy

Amazing Smiles Dentistry is privileged to provide dental treatment to our patients. We will work diligently to maintain a high level of personalized service and will strive to accommodate our patients' need for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.
We understand that emergencies arise from time to time, just as they do for us; however, when a patient fails an appointment or cancels without adequate notice, we cannot use that time to meet the needs of other patients. We respectfully request your understanding and agreement to our policy as it is stated below.

New Patients:
We will give you a reminder phone call and text message within at least 48 hours of your scheduled appointment. New patients who fail or cancel initial appointments with less than 48 hours' notice prior to the appointment will be required to pay a fee of $50 for a hygiene visit and $50 for a dentist visit before scheduling another appointment. For Monday appointments, cancellations must be made by noon on the preceding Friday. Cancellations may not be called into our answering service.

Established Patients:
Established patients who fail or cancel appointments with less than 48 hours' notice prior to the appointment will receive a letter or phone call informing them of the missed appointment. A second such occurrence will result in a $50 fee for missed hygiene visits and a $50 fee for missed dentist visits. Fees must be paid before rescheduling. A third such occurrence will result in dismissal from the practice.

Missed Appointments for Major Procedures:
Missed appointments for major procedures have a significant impact on our scheduling and resources. For missed major procedure appointments, there will be a $75 fee applied to your account, plus an additional 20% of the cost of the procedure.
For Monday appointments, cancelations must be made by noon on the preceding Friday. Cancellations may not be called into our answering service.
The scheduling parent or scheduling legal guardian of minors who fail or cancel appointments with less than 48 hours' notice will be held responsible for the missed appointments.

Fees:
Fees charged by Amazing Smiles Dentistry pursuant to this policy are not payable by insurance companies.
All fees must be paid prior to your scheduling another appointment or within 30 days of a billing statement, whichever is earlier.

X _____
Patient/Legal Guardian Signature

X _____
Date

01/01/2024