



PATIENT INFORMATION

Patient \_\_\_\_\_ Mr \_\_\_ Ms\_\_\_ Mrs \_\_\_ Dr\_\_\_ Hon\_\_\_
Last name First name Middle initial

I prefer to be called \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_ Drivers Lic# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer/Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Person Responsible for Account (if other than Patient):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_ Drivers Lic# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*\* You may refuse to Sign this Acknowledgement\*\*

I have received a copy or have been given access to the O'Neal Smiles, LLC Notice of Privacy Practices. I give my permission to O'Neal Smiles, LLC to

- Communicate with other health care professionals and dental insurance carriers (if applicable) as needed throughout the course of my care.
- Leave messages for me at my contact numbers provided and mail or email reminders to me regarding appointment dates and times.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

DATE

O'NEAL SMILES, LLC • BRANDON K. O'NEAL, DMD

PATIENT AGREEMENT

FINANCIAL OPTIONS:

Payment for services rendered is due and payable at the time of treatment unless arrangements have been made in advance. We accept Cash, Personal Checks, American Express, Visa, Mastercard, Discover and CareCredit.

- There is a \$35 NSF check charge for returned checks.
• Past due amounts are subject to 1 1/2% monthly interest (18% annual percentage rate (APR)).

As a courtesy to our patients, we work with several third party financing companies that may afford you the opportunity to make monthly payments for your treatment. Some companies offer low interest plans to qualified applicants. Please inquire if you are interested in applying.

Responsible Party policy for minor children: The policy in our office is that the parent who requests treatment for and accompanies the child to the office is responsible for all fees incurred.

DENTAL INSURANCE: As a courtesy to our patients we are happy to submit claims to your PRIMARY dental insurance company. Your dental benefits are dependent on the plan that you or your employer have selected and it is important that YOU BECOME AN EXPERT ON YOUR PARTICULAR INSURANCE PLAN BENEFITS; especially to the extent that it will be a factor in your treatment decisions.
We ask that you...
We will...
The following information is required to allow us to process insurance for our patients:
Primary Carrier Name and Address:
Patient relationship to Employee: Subscriber birthdate:
Subscriber name & address:
Subscriber ID# Subscriber gender: M F
Subscriber's Employer Group/Policy #

I have been informed of O'Neal Smiles, LLC financial and appointment policies. I agree to be responsible for all fees for services and materials incurred during the course of my treatment. To the extent permitted by law, I consent to the use of my protected health information by O'Neal Smiles, LLC to carry out payment activities in connection with my care.

Signature of Patient or Responsible Party Date

I hereby authorize payment of the insurance benefits otherwise payable to me directly to O'Neal Smiles, LLC.

Signature Date

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## Health Information

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Are you now under the care of a physician? Yes  No

If yes, please explain: \_\_\_\_\_

**2. Are you allergic to or have you had any reactions to the following? Please check all that apply:**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> Penicillin or any other Antibiotics  | <input type="checkbox"/> Sulfa Drugs  |
| <input type="checkbox"/> Barbiturates                      | <input type="checkbox"/> Sedatives                            | <input type="checkbox"/> Iodine       |
| <input type="checkbox"/> Aspirin                           | <input type="checkbox"/> Any Metals (eg nickel, mercury, etc) | <input type="checkbox"/> Latex Rubber |
| <input type="checkbox"/> Other: _____                      |   |                                       |

**3. Have you ever had any of the following? Please check those that apply:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Jaundice                  | <input type="checkbox"/> Respiratory Problems         |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Fainting/Seizures   | <input type="checkbox"/> Joint Replacement/Implant | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Angina            | <input type="checkbox"/> Frequently Tired    | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Leukemia                  | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths             | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Stomach Problems             |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Low Blood Pressure        | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Mental Disorders          | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Tumors                       |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Pain in Jaw Joints        | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment       | _____   |

4. Have you been admitted to a hospital or needed emergency care during the past two years? Yes  No

If yes, please explain: \_\_\_\_\_

5. Do you use tobacco? Yes  No

6. Women Only:

Are you pregnant or think you may be pregnant? Yes  No

Are you nursing? Yes  No

Are you taking oral contraceptives? Yes  No

7. Are you currently taking any prescription or over-the-counter medications? If yes, please list:

\_\_\_\_\_

8. Do you have any health problems that need further clarification? Yes  No

If yes, please explain: \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of Patient, Parent or Guardian

Date

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**Dental History**

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1. Date of Last Dental Visit: \_\_\_\_\_ Reason for this Visit: \_\_\_\_\_
2. Have you ever had any complications following dental treatment? Yes  No   
If yes, please explain: \_\_\_\_\_
3. Do you have any concerns about previous dental care or this dental visit? Yes  No   
If yes, please explain: \_\_\_\_\_
4. Do your gums bleed? Yes  No
5. Are your teeth loose? Yes  No
6. Have you ever been told that you have bad breath? Yes  No
7. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure
8. Do you feel your teeth are starting to get longer? Yes  No
9. Do you get food stuck between your teeth easily? Yes  No
10. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes  No
11. What would you change about the condition of your mouth? \_\_\_\_\_  
\_\_\_\_\_
12. Please check any statement that you agree with about your smile:
  - I wish my teeth were whiter.
  - I wish I had a bigger smile.
  - I think some of my teeth are too small.
  - I think some of my teeth are too large.
  - I wish my teeth were straighter.
  - My gums show too much when I smile.
  - I think there is too much space between some of my teeth.
  - Because I am not totally pleased with my smile, I sometimes hesitate to smile.
  - I have often wished I could change some of the features of my smile.
  - I think I need to do a better job of protecting the health of my smile.

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Signature of Patient, Parent or Guardian

Date



## APPOINTMENT POLICY

Dr. O'Neal's office is proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today.

**Effective January 1, 2008**, there will be a \$50.00 fee charged to your account for each patient scheduled and confirmed that cancels or breaks an appointment without 48 hour notice. Our office schedules each patient to see the doctor in a scheduled manner however we do understand that emergencies occur. When patients cancel or don't show up for an appointment without a reasonable notice we cannot possibly find a patient to fill in your time slot in such a short notice. We must prevent costs and loss of income by making sure that you understand our office's **BROKEN APPOINTMENT POLICY**.

There will be a 10-minute grace period after your appointment time. If there is any reason why you are running behind schedule for your appointment, we ask that you call the office to notify someone in our front office regarding your appointment time. If you are more than 10 minutes late we will have to ask you to reschedule your appointment to see the doctor or the hygienist. We ask for your cooperation so that all of our patients can be seen on time rather than waiting a long time. Please be sure that you understand the **OFFICE POLICY** when running late for an appointment.

**I have read and understand the above office policy.**

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_