Today's Date:_____

PATIENT INFORMATION

Patient Name:_____ Birth date:_____
First MI Last

Address:_____
Street City State Zip

Home #_____ Cell #_____ Work #_____

Marital Status:_____ Spouses Name:_____

Patient's Employment:_____
If a minor please give parent's or guardian's name and place of employment
Parent / Guardian Name:_____

Will you be paying by: CASH_____ CHECK_____ CREDIT CARD?_____

DENTAL INSURANCE INFORMATION

Insured's Name:_____ Insured's SS #_____ DOB_____
Insured's Employer:_____
Insured's Employer Address:_____
Dental Insurance Company:_____
Dental Insurance Address:_____
Dental Insurance Phone #_____ Group I.D. #_____

Patient covered by second dental insurance? YES NO IF YES COMPLETE

Insured's Name:_____ Insured's SS #_____ DOB_____
Insured's Employer:_____
Insured's Employer Address:_____
Dental Insurance Company:_____
Dental Insurance Address:_____
Dental Insurance Phone #_____ Group I.D. #_____

EMERGENCY NOTIFICATION INFORMATION
In case of emergency, who should be notified?

Name:_____ Relationship:_____ Phone #_____
Address:_____
Street City State Zip

REGISTRATION FORM

Patient Name:_____

Name, Address & Phone of Physician:_____

List all medications you are taking including any over the counter, vitamin or herb supplements:_____

_____

_____

CIRCLE

YES NO Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by any of the following (please circle): latex, penicillin, sulfa, xylocaine or other local anesthetics, general anesthesia, aspirin, codeine, foods (nuts, bananas, etc.) or any other drugs, medications or metals? _____

YES NO Do you carry an epi-pen or inhaler?

YES NO Have you had any excessive bleeding requiring special treatment?

YES NO Do you have a family history of Malignant Hyperthermia?

YES NO Do you smoke or chew tobacco?

YES NO Do you have a sore in your mouth or anywhere else that has been there 10 days or longer?

YES NO If female, are you pregnant?

YES NO Have you been told to take an antibiotic prior to having dental treatment?

YES NO Have you taken any cortisone medicines (such as Prednisone) regularly during the last 6 months?

CIRCLE any of the following which you have had or have at present:

Heart Disease
Heart Attack
Any Type of Implant:
(Heart Valve, Stent, Pacemaker, etc.)
History of Endocarditis
Rheumatic Fever
Organ Transplant
High Blood Pressure
Low Blood Pressure
Stroke
Blood Transfusions
Blood Thinners (**Coumadin, Plavix, Aspirin, etc.**)
Thyroid Disease
Cancer (Type:_____)
Chemotherapy
Radiation
Osteoporosis/Osteopenia
Bone Mass Drugs (Oral or I.V.)
(**Fosamax, Actonel, Boniva, Zometa, etc.**)

Tuberculosis (TB)
Epilepsy or Seizures
Fainting or Dizzy Spells
Sinus Trouble
Asthma
Allergies or Hives
Sexually Transmitted Diseases
HIV Positive/AIDS
Drug Addiction
Human Papillomavirus
Herpes, Genital or Oral
Diabetes
Arthritis
Artificial Hip, Knee or Other Joint
Kidney Trouble
Hepatitis (Type:_____)
Liver Disease
Ulcers

Further explanation of any hospitalization, medical conditions or illnesses_____

_____

_____

Signature:_____ Date:_____

HEALTH HISTORY

First Nickname Middle Last Date

Accurate answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time?_____ ☐Yes ☐No
2. Have you ever had any serious trouble associated with previous dentistry?_____ ☐Yes ☐No
3. Does dental treatment make you nervous?_____ ☐No ☐Slightly ☐Moderately ☐Extremely
4. Date of last dental visit?_____
5. Have you ever been treated for periodontal disease?_____ ☐Yes ☐No
   (gum disease, pyorrhea, trench mouth)?
6. Do you have or have you ever had any of the following:

Bleeding, sore gums	☐Yes ☐No	Loose teeth	☐Yes ☐No
Unpleasant taste/bad breath	☐Yes ☐No	Sensitive to hot	☐Yes ☐No
Burning tongue/lips	☐Yes ☐No	Sensitive to cold	☐Yes ☐No
Frequent blister,lips/mouth	☐Yes ☐No	Sensitive to sweets	☐Yes ☐No
Swelling/lumps in mouth	☐Yes ☐No	Sensitive to biting	☐Yes ☐No
Ortho treatments (braces)	☐Yes ☐No	Food impaction	☐Yes ☐No
Biting cheeks/lips	☐Yes ☐No	Clenching/grinding	☐Yes ☐No
Clicking/popping jaw	☐Yes ☐No	If so, when?_____	
Difficulty opening or closing jaw	☐Yes ☐No	Change in bite	☐Yes ☐No
Ice chewing habit	☐Yes ☐No	Gag reflex	☐Yes ☐No

7. Do you use the following?

Water-Pik	☐Yes ☐No	Dental floss	☐Yes ☐No
Fluoride rinse	☐Yes ☐No	Other _____	
Anti-bacterial rinse	☐Yes ☐No	Rubber tip	☐Yes ☐No

8. How often do you brush?_____ Brush is:_____ ☐Soft ☐Medium ☐Hard

These are the things that are important to me about my dental health_____

Do you have fears about dental care? If so, what:_____

Circle One:

1. **My mouth is:**
   a) very comfortable
   b) moderately comfortable
   c) uncomfortable
2. I____a) think the appearance of my mouth is excellent
   b) am satisfied with the appearance of my mouth
   c) am dissatisfied with the appearance of my mouth
3. **I think my present state of dental health is:**
   a) Excellent
   b) Good
   c) Poor
4. I____a) have set goals for my oral health with a previous dentist
   b) want to set goals concerning my dental health
5. I____a) have always done the best that was recommended for my dental health
   b) have not done what dentists have recommended to me
   c) rarely go, and don't care much about having any dental work completed
6. I____a) have put dentistry for myself and my family high on my priority list
   b) put dentistry for myself and my family lower on my priority list
   c) put dentistry on my list but it's hard to find
7. I____a) will do anything to keep my natural teeth
   b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them

What are some questions about dentistry and oral health that you have never had adequately answered?

DENTAL QUESTIONAIRE

Smile Solutions, LLC

98 Silver St.
Waterville, ME 04901
Peter Laliberte D.M.D., M.A.G.D. Jay Wietecha D.M.D., M.A.G.D.
Peter Vayanos, D.M.D.

FINANCIAL AGREEMENT

Insurance

If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our insurance policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. Please assist us in complying with your insurance requirements by keeping us up to date with your most current information. We will gladly submit fees for your covered dental services to your insurance company; however, we expect your co-payment at the time of service.

It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits; including pre-certifications, referral, and authorization requirements and to be sure all information is correct. If you give us the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to all patients, all charges are ultimately your responsibility from the date services are rendered.

Payment for Services

Payment for services including insurance co-payment or self-pay balance amount, is due at the time services are rendered. We accept most credit cards, including Care Credit as well as checks and cash payments. **Returned checks will result in a $25 fee that will be posted to your account.** Returned check, balances older than 60 days, and failure to pay account balances may be subject to external collection and additional collection fees, monthly interest, including attorney and other court costs. Interest will be accrued in the amount of 1.5% for every month the balance is overdue.

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We must empathize that as dental care providers, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Cancelled Appointments

Charges may be incurred for broken, confirmed appointments and appointments cancelled without 24 hours notice. Your cooperation in cancelling your scheduled appointment well in advance shows us the opportunity to offer your appointment to another person in need of dental care. **Failure to show for a scheduled, confirmed appointment may result in a $50 cancellation fee.**

If you have any questions about the above information, please do not hesitate to ask us.

Thank you!

My signature below constitutes acknowledgement and acceptance of this policy:

Patient name (printed): _____

Patient or guardian signature: _____

Date: _____