564 Old York Road
Etters, PA 17319
Phone: (717) 938-1811
Fax: (717) 938-1815
contact@welovebeautifulsmiles.com
www.welovebeautifulsmiles.com

PATIENT INFORMATION

First Name_____Last Name_____MI____Preferred_____

Home Address: _____City:_____State:___Zip:_____

Date of Birth _____/_____/_____ SSN_____-____-_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Cell Phone:_____Home Phone:_____Work Phone:_____

Email:_____

****ONLY IF UNDER 18 YEARS OF AGE****

PARENT/LEGAL GUARDIAN INFORMATION

First Name_____Last Name_____MI____Preferred_____

Date of Birth _____/_____/_____ SSN_____-____-_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____City:_____State:___Zip:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Primary Phone Number:_____ Secondary Phone Number:_____

PHYSICIAN & PHARMACY

Physician Name:_____ Pharmacy Name:_____

Address:_____ Address:_____

Phone Number:_____ Phone Number:_____

Date of Last Physical:_____ Fax Number:_____

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MEDICAL HISTORY

How would you rate your overall health? □ Good □ Fair □ Poor

Are you currently under the care of a physician for an ongoing condition? □ Yes □ No

Any serious illness, operations, or been hospitalized within the past 5 years? □ Yes □ No

If yes, for what reason? _____

Have you had any cosmetic procedures or elective surgeries completed? □ Yes □ No

If yes, please describe: _____ Treating Physician: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Have you had medical x-rays in the last 5 years? (CT Scan/MRI, etc.) □ Yes □ No

If yes, please explain: _____

MEDICATIONS & SUPPLEMENTS

Name	Dose	Frequency	Reason

ALLERGIES

IF NO ALLERGIES CHECK NONE: □ **NONE**

Type	Reaction (i.e. itching, rash, swelling of hands, eyes, or feet)
□ Drugs/Other Medications	
□ Foods	
□ Metals	
□ Other	

Reviewing Doctor's Signature **Date**

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Do you take aspirin on a daily basis? ☐ Yes ☐ No

Have you been told to take antibiotics prior to dental work? ☐ Yes ☐ No
If yes, for what reason? _____

Do you use tobacco? ☐ Yes ☐ No **Do you vape?** ☐ Yes ☐ No **Do you use marijuana?** ☐ Yes ☐ No

Have you been prescribed a medical marijuana card? ☐ Yes ☐ No

Do you, or have you used recreational or street drugs? ☐ Yes ☐ No If yes, how often? _____

If yes, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not Interested

Do you drink alcoholic beverages? ☐ Yes ☐ No **How Many per Week?** ☐ < 1 ☐ 2-4 ☐ > 5

When using stairs or taking a walk, do you ever have to stop because of chest pain? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you wake up short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No
If yes, please describe here: _____

Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No

Do you have any disease, condition, or problem that was not previously listed? ☐ Yes ☐ No
If yes, please describe here: _____

*****WOMEN ONLY*****

Are you pregnant? ☐ Yes ☐ No **Are you looking to become pregnant?** ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No **Are you using a contraceptive?** ☐ Yes ☐ No

If yes, initial the following statement: I understand that taking antibiotics may render contraceptives ineffective. _____

Reviewing Doctor's Signature **Date**

Beautiful SMILES
Family Dental Center

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MEDICAL CONDITIONS

Check any of the following conditions you currently have *or have had* in the past:

CARDIOVASCULAR CONDITIONS — If none of these apply check: ☐ NONE

☐ Angina
☐ Arteriosclerosis
☐ Artificial Valves
☐ Chest Pain Upon Exertion
☐ Congenital Heart Failure
☐ Coronary Artery Disease
☐ Congenital Defect
☐ Damaged Heart Valves
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ High Blood Pressure
☐ Irregular Heartbeat
☐ Mitral Valve Prolapsed
☐ Pacemaker
☐ Rheumatic Heart Disease
☐ Scarlet Fever
☐ Stroke
☐ Other (please specify): _____

RESPIRATORY CONDITIONS — If none of these apply check: ☐ NONE

☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Hay Fever
☐ Persistent Cough/Produces Blood
☐ Shortness of Breath
☐ Sinus Problems
☐ Tuberculosis (TB)
☐ Other (please specify): _____

BLOOD DISORDERS — If none of these apply check: ☐ NONE

☐ Abnormal Bleeding
☐ Anemia
☐ Blood Transfusion
☐ Bruise Easily
☐ Excessive Bleeding
☐ Hemophilia
☐ Leukemia
☐ Sickle Cell Disease
☐ Other (please specify): _____

PSYCHOLOGICAL CONDITIONS — If none of these apply check: ☐ NONE

☐ Anxiety ☐ Depression ☐ Nervousness ☐ Psychiatric Treatment
☐ Other (please specify): _____

LIVER CONDITIONS — If none of these apply check: ☐ NONE

☐ Cirrhosis/Liver Disease ☐ Hepatitis ☐ Jaundice
☐ Other (please specify): _____

OTHER HEALTH CONDITIONS — If none of these apply check: ☐ NONE

☐ Allergies or Hives
☐ Arthritis
☐ Artificial joint
☐ Cancer
☐ Chemotherapy
☐ Cold Sores/Fever Blisters
☐ Cortisone Medication
☐ Diabetes
☐ Drug Addiction
☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells
☐ Glaucoma
☐ Herpes
☐ HIV Antibody/AIDS
☐ Kidney Disease/Dialysis
☐ Measles
☐ Mumps
☐ Radiation Treatment
☐ Rheumatism
☐ STD
☐ Stomach Problems
☐ Thyroid disease
☐ Tumor
☐ Ulcers

_____ _____

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MEDICAL HISTORY ACKNOWLEDGEMENT

To the best of my knowledge all the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to **all** appointments.

APPOINTMENT POLICY

Appointments are time specifically reserved with our providers for you. If you must change an appointment, please provide us with at least **2 business days' notice** so that we may use our time to accommodate other patients. **Late cancellations or no-show appointments will result in a charge assessed to your account. $75 will be applied for the first hour with a subsequent charge of $50 for each additional 30 minutes of your remaining appointment time.** Appointments 90 minutes or greater in length will require a $75 deposit. If you fail to provide the requested notice, your deposit will be retained and applied to the broken appointment fee. Another deposit will be required to reschedule the appointment. Anesthesia cases require a deposit equal to the estimated anesthesia cost, due at the time of scheduling, with the remaining amount due at the time of service. **Failure to provide 3 business days' notice of cancellation will result in forfeiting the entire deposit.** If you cancel or fail to show for three (3) or more appointments within a one (1) year period, we may terminate our professional relationship with you. Arriving 15 minutes, or more, late for your appointment may result in a broken appointment. After hours and weekend appointments will result in a $250 fee for existing patients and $350 fee for new patients. Parents are asked to remain in the waiting room during your child's appointment unless invited into the operatory by the doctor.

FINANCIAL POLICY

Co-Payments & Insurance:

If you have dental insurance, our office staff will assist you by submitting insurance forms and verifying the coverage that your insurance plan provides. You are responsible for any applicable deductible amounts and the estimated portion that your insurance does not cover, **on or before** your scheduled appointment unless other financial arrangements have **previously** been made with the Office Manager. Please be advised that although our office will make every effort to accurately ***estimate*** what your insurance will pay, this ***does not, in any way***, guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedure(s). Uninsured patients are responsible for payment at the time of service.

Payment Options and Finance Charges/Fees:

For your convenience we accept Cash, Check, Visa, MasterCard, Discover and American Express. We also offer Care Credit, a financing program that offers monthly payment options. No post-dated checks will be accepted, nor can we accept personal checks at your first appointment with us. Balances more than 30 days are subject to a finance charge of 1.5% per month (18% annual). Balances more than 60 days will be considered delinquent. Returned checks are subject to a $35 accounting fee.

AUTHORIZATION AND CONSENT

I acknowledge that I have read and understand the preceding policies and that I may request a copy of the policy. By signing this form, I acknowledge that Beautiful Smile Family Dental Center may change any or all the policies as outlined above. I agree to pay for all services rendered by this office. I authorize and request my insurance company to pay my benefits directly to BSFDC. I also understand that should my account become delinquent, my information may be released to a third-party collection agency to assist with collecting fees associated with treatment rendered at this office and that I will be responsible for any expenses associated with such action. I agree and consent to a dental examination by Dr. Graver or Associate Doctor(s). I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I also authorize BSFDC to release any information regarding my medical/dental history, diagnosis or treatment to third party payers and/or other health professionals.

This agreement and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures appearing on this agreement, or such other documents are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

Responsible Party's Name	**Type Name for Signature**	**Date**

Reviewing Doctor's Signature	**Date**

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HIPAA/NOTICE OF PRIVACY PRACTICES

I,_____, have been informed of the office's Privacy Practices and Patient Bill of Rights
Print Full Name of Patient/Parent/Legal Guardian and understand I may request a printed copy if desired.

I authorize Beautiful Smiles Family Dental Center to speak with the following individual(s) about the full extent of my dental treatment, financial records, insurance policy and appointment scheduled:

Name: Relationship: Phone Number:

Name: Relationship: Phone Number:

I give my consent to the doctors, clinical and business teams of Beautiful Smiles Family Dental Center to leave detailed messages or discuss scheduling, treatment, finances, surgery and any other information regarding my care, account, or insurance as follows:

- ☐ Voice messages on cell phone or home phone number
- ☐ Voice messages at work phone number
- ☐ Text Messages
- ☐ E-mail
- ☐ I do not consent to detailed messages being left at my home, work, email, or cell phone.

This agreement is valid for the duration of my treatment at Beautiful Smiles Family Dental Center. You have the right to refuse to sign this acknowledgement. I understand that I have the right to revoke this consent to release protected health information. A written, signed, and dated notice revoking the authorization must be submitted to the office to initiate the request.

This agreement and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures appearing on this agreement, or such other documents are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

Patient Name (Printed) **Type Name for Signature** **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other (please specify)