

SMILE STUDIO

Mount Laurel

801 S. Church Street
Mount Laurel | NJ | 08054
P: 856.866.5511 | F: 856.866.0051

Patient Name:
Preferred Name (if applicable):
Date of Birth:
Sex (Assigned at Birth): ☐ M ☐ F
Gender Identity (Optional):
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
SSN:
E-mail:
Primary Phone:
☐ Home ☐ Mobile ☐ Work
Secondary Phone (if applicable):
☐ Home ☐ Mobile ☐ Work
Mailing Address:
City:
State & ZIP:

Emergency Contact Information

Name:
Relationship:
Primary Phone:
☐ Home ☐ Mobile ☐ Work
Secondary Phone (if applicable):
☐ Home ☐ Mobile ☐ Work

**If the patient is under 18 years of age,
please complete section:**

Guarantor Name:
Relationship to Patient:
Date of Birth:
Mailing Address: ☐ Same as Patient
City:
State & ZIP:
SSN:
Primary Phone:
☐ Home ☐ Mobile ☐ Work

Primary Insurance Information

**If you do not currently have dental insurance, please skip
this section.**

Dental Insurance Company:
Member ID:
Group Number:
Name of Subscriber:
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Date of Birth:
Subscriber's SSN:
Subscriber's Employer:
Occupation:

Secondary Insurance Information

**If you do not currently have secondary dental insurance,
please skip this section.**

Dental Insurance Company:
Member ID:
Group Number:
Name of Subscriber:
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Date of Birth:
Subscriber's SSN:

How did you hear about us? If someone referred you
to our office, who should we thank?

By signing below, I affirm that the information contained
within is accurate to the best of my ability. I agree to inform
Smile Studio of any changes to this information.

Signature: _____

Date: _____

Patient Medical History

Patient Name _____ Date of Birth _____

Primary Care Physician _____ Practice Location _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Y N

Do you have, or have ever had:

Y N

1. Hospitalization for illness or injury _____ ☐ ☐

2. An allergic or bad reaction to any of the following: ☐ ☐

☐ aspirin, ibuprofen, acetaminophen, codeine _____

☐ penicillin _____

☐ erythromycin _____

☐ tetracycline _____

☐ sulfa _____

☐ local anesthetic _____

☐ fluoride _____

☐ chlorhexidine (CHX) _____

☐ Iodine _____

☐ metals (nickel, gold, silver, etc.) _____

☐ latex _____

☐ nuts _____

☐ fruit _____

☐ milk _____

☐ red dye _____

☐ other _____

3. Heart problems, or cardiac stent within the last six months ☐ ☐

4. History of infective endocarditis _____ ☐ ☐

5. Artificial heart valve, repaired heart defect (PFO) _____ ☐ ☐

6. Pacemaker or implantable defibrillator _____ ☐ ☐

7. Orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____ ☐ ☐

8. Heart murmur, rheumatic or scarlet fever _____ ☐ ☐

9. High or low blood pressure _____ ☐ ☐

10. A stroke (taking blood thinners) _____ ☐ ☐

11. Anemia or other blood disorder _____ ☐ ☐

12. Prolonged bleeding due to a slight cut (or INR > 3.5) _____ ☐ ☐

13. Pneumonia, emphysema, shortness of breath, sarcoidosis _____ ☐ ☐

14. Chronic ear infections, tuberculosis, measles, chicken pox _____ ☐ ☐

15. Breathing problems (e.g., asthma, stuffy nose, sinus congestion) _____ ☐ ☐

16. Sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____ ☐ ☐

17. Kidney disease _____ ☐ ☐

18. Liver disease or jaundice _____ ☐ ☐

19. Vertigo (e.g., "the room is spinning") _____ ☐ ☐

20. Thyroid, parathyroid disease, calcium deficiency _____ ☐ ☐

21. Hormone deficiency or imbalance _____ ☐ ☐

22. High cholesterol or taking "statin" drugs _____ ☐ ☐

23. Diabetes (HbA1c = _____) ☐ ☐

24. Stomach or duodenal ulcer _____ ☐ ☐

25. Digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____ ☐ ☐

26. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____ ☐ ☐

27. Arthritis or gout _____ ☐ ☐

28. Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____ ☐ ☐

29. Glaucoma _____ ☐ ☐

30. Contact lenses _____ ☐ ☐

31. Head or neck injuries _____ ☐ ☐

32. Epilepsy, convulsions (seizures) _____ ☐ ☐

33. Neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) _____ ☐ ☐

34. Viral infections and cold sores _____ ☐ ☐

35. Any lumps or swelling in the mouth _____ ☐ ☐

36. Hives, skin rash, hay fever _____ ☐ ☐

37. STI/STD/HPV _____ ☐ ☐

38. Hepatitis (type _____) _____ ☐ ☐

39. HIV/AIDS _____ ☐ ☐

40. Tumor, abnormal growth _____ ☐ ☐

41. Radiation therapy _____ ☐ ☐

42. Chemotherapy, immunosuppressive medication _____ ☐ ☐

43. Emotional difficulties _____ ☐ ☐

44. Psychiatric treatment, antidepressant medication _____ ☐ ☐

45. Concentration problems or ADD/ADHD _____ ☐ ☐

46. Alcohol/recreational drug use _____ ☐ ☐

ARE YOU:

47. Presently being treated for any other illness _____ ☐ ☐

48. Aware of change(s) in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____ ☐ ☐

49. Taking medication for weight management _____ ☐ ☐

50. Taking dietary supplements, vitamins, and/or probiotics _____ ☐ ☐

51. Often exhausted or fatigued _____ ☐ ☐

52. Experiencing frequent headaches or chronic pain _____ ☐ ☐

53. A smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____ ☐ ☐

54. Considered a touchy/sensitive person _____ ☐ ☐

55. Often unhappy or depressed _____ ☐ ☐

56. Taking birth control pills _____ ☐ ☐

57. Currently pregnant _____ ☐ ☐

58. Diagnosed with a prostate disorder _____ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment (e.g. Botox, Collagen Injections)

Signature: _____ Date: _____

SMILE STUDIO

Mount Laurel

801 S. Church Street

Mount Laurel | NJ | 08054

P: 856.866.5511 | F: 856.866.0051

Please complete the medication list on the reverse side of this page.

Medication List

If you already have a list of your active medications, please provide a copy to our staff

Please fill in the chart below with all current active medications, including over-the-counter medications (such as multivitamins or eye drops).

If you do not take any active medications, please write "N/A" in the first box and sign below.

Preferred Pharmacy Name: _____ Location: _____ Phone Number: _____

Name of Medication	Dose	Reason for Medication

By signing below, I affirm that the information contained within is whole and accurate to the best of my ability. I agree to inform Smile Studio of any changes to this information. I understand that failure to provide accurate and up-to-date health information can impact the outcome of my care.

Signature _____ Date _____

Staff Only:

☐ Patient-provided medication list

Patient Dental History

Patient Name _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam _____ I routinely see the dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely
 Date of most recent x-rays _____
 Do you have any immediate concerns? _____

Please answer YES or NO to the following:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease, had scaling/root planing, or been told you have lost bone around your teeth? _	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit? _	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31. Do you have problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or awareness of your teeth? _	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient/Guarantor Signature: _____ Date: _____

Insurance Billing Policy & Information

It is the intent of this office to ASSIST you with your insurance benefit information. We are currently contracted with Aetna, Ameritas-Affiliation Aetna, Careington-Platinum PPO, Cigna-DPPO, Delta Dental-PPO/ Premier/Advantage, GEHA-Connection Dental Affiliation, Guardian-Affiliation, HZN BCBS-Traditional, Humana- Affiliation, MetLife- Affiliation, and Principle-Affiliation. As per our Patient Consent form, we will submit a claim to any policy that offers out-of-network benefits as a courtesy to you.

We are NOT responsible for ANY information provided to us as a courtesy to you by your insurance company.

Sometimes it is difficult to obtain reliable financial information from insurance companies regarding certain procedures. Contract allowances have many conditions for eligibility established by the insurance carrier not based on need for the service. These conditions for eligibility continually change and we are not apprised of the changes.

Treatment Fees and Payment:

- Payment for services rendered is expected at time of treatment.
- Estimated payments and co-payments are due at the time of your appointment.
- Pre-treatment estimates can be submitted to your insurance company so that they can provide you with financial information regarding the amount they may or may not pay towards treatment. Any quotes are ESTIMATES only.

Insurance Estimates and Claims:

- I understand that estimates of insurance benefits for services performed both verbal and written are only estimates. I understand this office attempts to obtain information about your benefits as a courtesy to you.
- I understand that any information this office provides you regarding benefit coverage is not a guarantee in any respect that the insurance company will pay this amount. I will not hold this office responsible for benefit information obtained on MY behalf. The information may not be accurate. Ultimately, this information is your responsibility, we are only assisting you.
- I understand that my dental or medical insurance carrier may pay less than the actual fee and/or estimate for services provided in writing and verbally. ALL estimates are non-binding.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I authorize Smile Studio to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or other health practitioners.

All balances are due in full 90 days after treatment regardless of insurance's intent to pay.

By signing below, I acknowledge I have read and understand the above entirely.

Patient/Guarantor Signature: _____ Date: _____

Patient Financial Information & Consent

By signing below, I affirm:

I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

I understand that I am responsible for paying my entire remaining balance either at point of service (if paying out of pocket), or as soon as my insurance company completes my claim (if billing insurance). I understand applicable copays for services will be estimated and collected on date of service, regardless of insurance status. Balances that remain unpaid after 90 days may be automatically processed via your payment method on file.

I understand that Smile Studio bills most insurance companies as a courtesy. However, Smile Studio is not contracted with Medicaid, or any other state-managed insurance plans or policies, and that Smile Studio will not bill these plans or policies, or any other policy at Smile Studio's discretion.

I understand that, in the cases of divorced families, the law considers the parent who brings the child to the appointment to be the responsible party.

I understand that it is my responsibility to advise Smile Studio of any changes in the information obtained in the forms I have filled out today as a new patient to this office.

I authorize the use of the social security number to file my dental claims (if applicable).

I agree to the receipt of automated appointment notifications and other communications via text or phone unless otherwise stated.

Patient/Guardian Signature: _____ Date: _____

Patient Name (Print): _____

Relationship to Patient (if applicable): _____

Witness: _____

HIPAA Notice of Privacy Practices and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in practice for years. This form is a "friendly" version. A more complete text is available at any time.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov. We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text message, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. You may opt out of appointment reminders at any time by request.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office staff or the doctor. You may also file any complaints with agencies as defined in our full Notice of Privacy Practices.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services, unless otherwise indicated by you.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. I consent to the use of photographs, radiographs and case history for educational purposes in schools, website and internet use in connection with Smile Studio. I relinquish any and all rights to photographs captured via digital camera for use by Smile Studio.
10. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing below, I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and HIPAA NOTICE OF PRIVACY PRACTICES and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient/Guardian Signature: _____ Date: _____

Appointment Confirmations

We may reach out to you via text, phone call, or email one week before your scheduled appointment to confirm your attendance. We respectfully request that you confirm your appointment at least 48 hours prior to the appointment time. Unconfirmed appointments may be subject to cancellation at the office's discretion.

Cancellations/No-Show Policy for Dental Hygiene Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. Additionally, we do not double-book our clinical staff, and set aside your scheduled appointment time for you exclusively. To allow us to continue offering this same comprehensive and personal care:

If an appointment is not canceled at least 48 hours in advance you may be charged an appointment cancellation fee starting at \$50.00, depending on the nature of the appointment and time scheduled; this will not be covered by your insurance company.

Cancellation/ No Show Policy for Treatment Appointments (Crowns/Bridges, Implants, Root Canals, etc.)

Due to the large amount of time needed for these appointments, last minute cancellations can cause issues and added expenses for our patients and office alike. Additionally, we do not double-book our clinical staff, and set aside your scheduled appointment time for you exclusively.

If an appointment is not canceled at least 48 hours in advance you may be charged an appointment cancellation fee starting at \$100.00, depending on the nature of the appointment and time scheduled; this will not be covered by your insurance company.

Account Balances

We require that patients with balances due to pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions may call and speak with the Financial Coordinator during business hours.

Lateness Policy

We understand that delays can happen, however we must try to keep our other patients and doctor on time. If a patient is 15 minutes past their scheduled appointment time, we will have to reschedule the appointment. Excessive lateness exceeding 15 minutes may count as a "no-call/no-show", and may result in a relevant fee being applied.

By signing below, I acknowledge I have read and agree to the above Policies

Patient/Guardian Signature: _____ Date: _____