SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

# NEW PATIENT FORM

We are continually concerned with your health and the care that is rendered to you. It is therefore important to update this information on a yearly basis. If you have any questions, please feel free to ask one of our staff members to assist you. Please print clearly.

## PATIENT INFORMATION

Date _____
Patient _____
Address _____
_____
City State Zip

SEX: ☐ M ☐ F Age _____ Birth Date _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____

Spouse's Name _____
Birthday _____ SS# _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____
_____

## DENTAL INSURANCE

Subscriber Name _____
ID# _____
Insurance Co. _____
Group # _____
Is Patient covered by additional Insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birth Date _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Smile Designs of South Florida, P.A. / Julie Nordman, D.M.D., P..A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature of Guarantor

_____
Relationship to Patient Date

## PHONE NUMBERS

Home _____ Cell _____ Work _____ Ext _____ Spouse's / Partner's Work _____
Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)
Name _____ Relationship _____
Home Phone _____ Work Phone _____

**FINANCIAL ARRANGEMENTS**: For your convenience, we offer the following methods of payment. Payment for services rendered is due at each appointment.

☐ Cash ☐ Personal check ☐ VISA ☐ MasterCard ☐ Discover ☐ I wish to inquire about Patient Finance Plans.

## DENTAL HISTORY

Reason for today's visit _____
_____
Former Dentist _____
City, State _____
Date of last visit _____
Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate If you have or ever had any of the following:

| | | |
|---|---|---|
| Bad breath | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Blister on lips or mouth | ☐ Yes | ☐ No |
| Burning Sensation on tongue | ☐ Yes | ☐ No |
| Removal of Dental Appliances | ☐ Yes | ☐ No |
| Chew on one side of mouth | ☐ Yes | ☐ No |
| Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No |
| Dry Mouth | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Gums swollen or sensitive | ☐ Yes | ☐ No |
| Shrinking Gums showing root surfaces | ☐ Yes | ☐ No |
| Jaw pain or tiredness | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Awaken with Headaches | ☐ Yes | ☐ No |
| Awaken with sore jaw muscles | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ Yes | ☐ No |
| Mouth breathing | ☐ Yes | ☐ No |
| Mouth pain, brushing | ☐ Yes | ☐ No |
| Orthodontic treatment | ☐ Yes | ☐ No |
| Pain around ear | ☐ Yes | ☐ No |
| Periodontal treatment | ☐ Yes | ☐ No |
| Sensitivity to cold | ☐ Yes | ☐ No |
| Sensitivity to heat | ☐ Yes | ☐ No |
| Sensitivity to sweets | ☐ Yes | ☐ No |
| Sensitivity when biting | ☐ Yes | ☐ No |
| Sores or growths in your mouth | ☐ Yes | ☐ No |

How often do you floss? _____
How often do you brush? _____
Do you brush too hard? ☐ Yes ☐ No
Are you interested in improving the appearance of your teeth? ☐ Yes ☐ No

SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

# NEW PATIENT FORM

## MEDICAL HISTORY

Place a mark on “Yes” or "No" to indicate if you have had any of the following:

1. Are you in good health? ☐ Yes ☐ No
2. Has there been any change in your health in the past year? ☐ Yes ☐ No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ☐ Yes ☐ No
   If so, for what condition? _____
5. The name and address of my physician is: _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ☐ Yes ☐ No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ☐ Yes ☐ No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) ? ☐ Yes ☐ No
   If so, please list including for how long: _____
   _____
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, herbal supplements, homeopathic or natural remedies? ☐ Yes ☐ No
   If so, please list: _____
   _____
10. Pharmacy Name and Phone Number: _____
    _____

11. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ☐ Yes ☐ No
    b. Rheumatic Heart Disease ☐ Yes ☐ No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ☐ Yes ☐ No
       1. Chest pain upon exertion? ☐ Yes ☐ No
       2. Shortness of breath after mild exercise? ☐ Yes ☐ No
       3. Do your ankles swell? ☐ Yes ☐ No
    d. Allergies ☐ Yes ☐ No
    e. Sinus trouble ☐ Yes ☐ No
    f. Asthma or hay fever ☐ Yes ☐ No
    g. Fainting spells or seizures ☐ Yes ☐ No
    h. Diabetes ☐ Yes ☐ No
    i. Hepatitis, jaundice or liver disease ☐ Yes ☐ No
    j. Frequent or recurring mouth sores ☐ Yes ☐ No
    k. Thyroid problems ☐ Yes ☐ No
    l. Respiratory problems, emphysema, bronchitis, etc. ☐ Yes ☐ No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ☐ Yes ☐ No
    n. Osteoporosis ☐ Yes ☐ No
    o. Stomach ulcer or hyperacidity ☐ Yes ☐ No
    p. Kidney trouble ☐ Yes ☐ No
    q. Tuberculosis ☐ Yes ☐ No
    r. Persistent cough or cough that produces blood ☐ Yes ☐ No
    s. Persistent swollen neck glands ☐ Yes ☐ No
    t. Low blood pressure ☐ Yes ☐ No
    u. Epilepsy or neurological disorder ☐ Yes ☐ No
    v. Cancer ☐ Yes ☐ No
    w. Any disease, drug or transplant operation that has depressed your immune system ☐ Yes ☐ No
12. Have you had abnormal bleeding? ☐ Yes ☐ No
    a. Have you ever required a blood transfusion? ☐ Yes ☐ No
13. Do you have any blood disorder such as anemia? ☐ Yes ☐ No
14. Have you ever had treatment for a tumor or growth? ☐ Yes ☐ No
15. Have you had radiation therapy to the head, neck or jaws? ☐ Yes ☐ No
16. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ☐ Yes ☐ No
    b. Penicillin or antibiotics ☐ Yes ☐ No
    c. Sulfa drugs ☐ Yes ☐ No
    d. Barbiturates or sleeping pills ☐ Yes ☐ No
    e. Aspirin ☐ Yes ☐ No
    f. Iodine ☐ Yes ☐ No

SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

# NEW PATIENT FORM

g. Codeine or other narcotics ☐ Yes ☐ No
h. Latex or rubber products ☐ Yes ☐ No
i. Other ☐ Yes ☐ No

17. Have you had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No
If so, explain: _____

18. Do you have any other condition or disease you think the doctor should know about? ☐ Yes ☐ No
If so, explain: _____

19. Do you smoke or chew Tobacco? ☐ Yes ☐ No
How much? _____

20. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ☐ Yes ☐ No

21. Are you wearing contact lenses? ☐ Yes ☐ No

22. Do you wish to talk with the doctor privately about anything? ☐ Yes ☐ No

**WOMEN:**

23. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

24. Do you have problems associated with your menstrual period? ☐ Yes ☐ No

25. Are you nursing? ☐ Yes ☐ No

26. Are you taking birth control pills? ☐ Yes ☐ No

Date: _____ Patient's Signature: _____

## FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date: _____ Doctor's Signature: _____

**MEDICAL HISTORY UPDATE:**

| Date | Comments | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

# NEW PATIENT FORM

## AUTHORIZATION FOR DENTAL TREATMENT

I, _____, hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics and / or x-rays which my dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as a matter of law, it shall be conclusively presumed:

A.) that the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities and from Information provided me by my dentist, I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatments or procedures:

OR

B.) That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph "A" above.

Executed this ____day of_____, 20 ___

Patient or authorized person on behalf of the patient:

_____
Name

_____
Signature

Witness:

_____
Name

_____
Signature

## OFFICE POLICIES

**PATIENT INSURANCE POLICY:**
We will be happy to file your claim for you and diligently pursue insurance payment. We will also gladly answer any questions you have on your insurance, and will help you understand your benefits due to you by your insurance company.

We will accept insurance as partial payment for services. However, patients must pay their portion of co-payment (amount that insurance does not cover) at each visit that services are rendered.

We work very hard to accurately estimate the amount that an insurance company will cover on any specific procedure. However, with hundreds of insurance policies and coverages, it is impossible to know with 100% assuredness what this amount will be. After we receive final payment from an insurance company, patients will be billed for any difference between our original estimate and the actual amount paid. Of course, if insurance payment was greater than the amount anticipated, we will promptly reimburse the patient for any difference.

If after 60 days from date of service, no insurance payment has been received, the patient will be expected to pay in full. Thereafter, a fee of 1½ % interest per month (18% APR) will be applied to the patients account until payment is received in full.

**BROKEN APPOINTMENT POLICY:**
We practice personalized quality gentle dentistry seeing only one patient at a time. A change in our schedule affects many patients as well as the normal operations of our office. Therefore, a charge of $35.00 per scheduled hour will be due to our office for appointments broken or canceled without a 24-hour notice

**DUPLICATION OF DENTAL RECORDS/ X-RAYS:**
Requested copies of records and/or x-rays will be charged a nominal duplication fee as permitted by Florida State Law.

I acknowledge and understand the above office policies. I also understand that I am responsible for all the charges from services rendered to me, or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the entire bill is paid within 60 days from the date of service. If for any reason, a portion of my bill is not paid within 60 days by my insurance, I will further agree to make payment in full for the remaining balance at that time,

Signed: _____

Date:_____