iSmile :)

Richard Ragnell, D.D.S.
1320 Village Creek #100 Plano, TX 75093
972-732-1818 www.iSmile-tx.com

Welcome to our practice! Please take a moment to enter OR update your information to help us ensure the quality of your dental is excellent. We are so glad you are here!

PATIENT'S INFORMATION

PATIENT'S NAME_____TODAY'S DATE_____

Home Address_____City_____State_____Zip_____

Email Address_____Home Ph_____Cell Ph_____

Preferred method of appt confirmation Email Home Ph Cell Ph Text (*Circle all that apply*)

SS#_____DL#_____Date of Birth_____

Marital Status: Single Married Separated Divorced Widowed (*Circle One*)

Occupation_____Employer Name_____

Business Address_____City_____Zip_____Bus Ph_____

Spouse's Name_____SS#_____Bus Ph_____

Spouse's Occupation_____Spouse's Employer_____

PERSON TO CONTACT IN AN EMERGENCY

Relationship_____

Home Ph_____Work Ph_____

RESPONSIBLE PARTY_____

Home Ph_____Work Ph_____

Who may we thank for referring you_____

Reason for this visit_____

PRIMARY INSURANCE INFORMATION

Name of Insured_____Date of Birth_____
SS#_____Subscriber ID_____
Group #_____Employer_____Insurance Co._____
Insurance Company Ph_____

SECONDARY INSURANCE INFORMATION

Name of Insured_____Date of Birth_____
SS#_____Subscriber ID_____
Group #_____Employer_____Insurance Co_____
Insurance Company Ph_____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you.

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

***DENTAL HEALTH HISTORY**

Your Previous Dentist_____City_____How Long?_____

Date of last visit_____Date of last dental cleaning_____Last X-Rays_____

Check any of the following you have had or currently have:

___Mouth Discomfort
___Red , swollen or bleeding gums
___Orthodontic Treatment
___Sensitive Teeth (hot, cold, sweet)
___Gums Bleed when Brushing
___Loose or Shifting Teeth
___Trouble Chewing or Speaking
___Bruise Easily
___Locking Jaw
___Grind or Clench your teeth
___Clicking, Popping or Pain in Jaw Joints
___Bad Dental Experience
___Wake with Sore Jaw
___Mouth Odor or Bad Taste
___Cold Sores or Fever Blisters
___Other Oral Lesions
___Lost/Broken Fillings
___Ringing in Ears
___ Close relative that wears dentures
___Gum Abscesses
___Complications with or following previous dental treatment
___Fear of Dental Treatment
___Stained Teeth
___Broken/Chipped Tooth

***MEDICAL HEALTH HISTORY**

How would you describe your present health? Excellent Good Fair Poor (*Circle One*)
List your current physicians:
_____Type_____Phone_____
_____Type_____ Phone_____

Date of last complete physical exam_____Purpose_____
Findings_____

Circle Yes or NO			**Explain**
Are you aware of any changes in your general health in the last year?	YES	NO	_____
Have you ever been hospitalized for illness or surgery in the past 2 yrs?	YES	NO	_____
Have you been under a medical doctor's care in the past 2 yrs?	YES	NO	_____
Have you had excessive bleeding that required special treatment?	YES	NO	_____
Is there any history of diabetes in your family?	YES	NO	_____
Are you required to restrict your work activity in any way?	YES	NO	_____
Are you on a specific restricted diet of any kind?	YES	NO	_____
Do you Smoke?	YES	NO	How much?_____How Long?_____
Do you snore?	YES	NO	
Do you consume alcohol?	YES	NO	
When you wake up in the morning do you feel rested?	YES	NO	_____
Do you fatigue easily as the day progresses?	YES	NO	_____

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

Penicillin	Vibramycin	Novacaine	Tylenol	Codeine	Other_____
Erythromycin	Sulfa Drugs	Carbocaine	Aspirin	Ibuprofen	_____
Tetracyclin	Keflex	Xylocaine	Latex	Anesthetics	_____

***Indicate which of the following you have had or have at present. Circle YES or NO**

Heart Trouble	YES	NO	Artificial Joint (knee, Hip)	YES	NO	Cancer or Tumors	YES	NO
Heart Disease or Attack	YES	NO	Kidney, Bladder Trouble	YES	NO	Radiation Treatment	YES	NO
Angina	YES	NO	Thyroid Disease	YES	NO	Chemotherapy	YES	NO
High Blood Pressure	YES	NO	Emphysema	YES	NO	Arthritis/Rheumatism	YES	NO
Low Blood Pressure	YES	NO	Persistant Cough	YES	NO	Glaucoma	YES	NO
Heart Murmur	YES	NO	Tuberculosis	YES	NO	Contact Lenses	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Hepatitis	YES	NO
Congenital Heart Lesions	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Artificial Heart Valve	YES	NO	Sinus Troubles	YES	NO	Jaundice	YES	NO
Scarlet Fever	YES	NO	Allergies or Hives	YES	NO	A.I.D.S.	YES	NO
Heart Pacemaker	YES	NO	Diabetes	YES	NO	Blood Transfusion	YES	NO
Heart Surgery	YES	NO	Frequent Thirst and/or			Drug or Alcohol Addiction	YES	NO
Shortness of Breath			Urination	YES	NO	Hemophelia	YES	NO
Upon Mild Exertion	YES	NO	Stroke	YES	NO	A Nervous Person	YES	NO
Require more than			Epilepsy or Seizures	YES	NO	Ulcers	YES	NO
Two pillows to sleep	YES	NO	Frequent Headaches	YES	NO	Bisphosphonates Therapy	YES	NO
Ankles Swell	YES	NO	Fainting or Dizzy Spells	YES	NO	Psychiatric Care	YES	NO
Anemia	YES	NO	Latex Allergy	YES	NO	Unintentional Weight		
Sickle Cell Disease	YES	NO	Osteoporosis	YES	NO	Gain/Loss	YES	NO
Osteopenia	YES	NO	Sleep Apnea	YES	NO	Recreational Drug Use	YES	NO

***If Female are you:**

Pregnant	YES	NO	Through with Menopause	YES	NO
Taking Birth Control	YES	NO	Taking Hormone Medication	YES	NO

***Do you have any medical condition/disease not listed on this page that we should know about?**

YES NO Explain_____

Please list all medications you are now taking, including any over the counter medications and supplements:

_____

_____

_____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform the doctor on or before my next appointment without fail.

_____ _____

Patients Signature Date Doctor's Signature Date

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or my dependents (if any).

Please list any parties who can have access to your dental information:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

Signature of Patient, Parent or Guardian Date Witness Date

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for, and grant the dental practice permission to securely upload my patient information to the web site.

Signature_____ Witness Signature_____

Patient Parent Guardian (*Circle One*) Date_____

CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to by me in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

MISSED APPOINTMENTS: We feel that our patient's time is valuable. When your appointment is made, a room is reserved for you and prepared for your particular needs. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. We understand that emergencies may arise which may cause you to miss or be late to an appointment and we will take that into consideration. However, if you do not notify us, and fail to keep our reserved appointment, your account may be charged a fee of $50.00. Keep in mind; our office hours are Monday – Wednesday from 7:00am to 5:00pm and Thursday from 8:00am to 2:00pm. The office is closed Fridays. We thank you for understanding.

___I have read the information above conditions of treatment and payment and agree to their content.

Signature_____ Witness Signature_____

Patient Parent Guardian (*Circle One*) Date_____