Patient Name: _____

Firewheel Smiles.com

4502 River Oaks Pkwy Suite 200, Garland, TX 75044 (214) 703-5490

Registration and Health History

Patient Information

Today's Date: _____ Reason for this visit: _____

Patient's Name: _____ DOB: _____ SS#: _____
(Last) (First) (MI)

Address: _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell# _____

DL # _____ Sex: _____ Martial Status: _____

Employer: _____ Email: _____

Person to contact in an emergency _____ Home# _____ Work # _____

If patient is a minor, give parent or guardian's name _____

How did you hear about our office? _____

Dental Insurance Information

Insured's Name: _____ Relation to patient: _____

Insured's SS#: _____ DOB: _____ Insured's Employer: _____

Insurance Company: _____

Claims Address: _____

Phone # _____ Group # _____ Effective Date of Coverage: _____

Insured's Address (if different than above):

Address: _____ City _____ State _____ Zip _____

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that I am responsible for all of the charges for all services rendered to me or any member of my family. I understand an assessment of $50 will be charged to my account if I fail to cancel any appointment without at least 48 hours notice.

Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill.

I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me:

Signed _____ **Date** _____

Patient Name: _____

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Dental Health History

It is important that we know your dental history. These facts have a direct bearing on your Dental Health. The information is kept strictly confidential in accordance with HIPAA guidelines. Thank you.

How long since you have seen a dentist? _____ Last complete exam? _____

Date your last x-rays were taken? _____

What is your major dental concern? _____

Previous Dentist's Name: _____ City _____ State _____

Y N If we could offer you a simple, effective way of whitening your teeth, would you be interested?
Y N If you could change one thing about your smile or dental health would you, and what would it be?

_____

Y N Are you aware of clenching or grinding teeth?
Y N Do you have frequent migraines, headaches, earaches, or neck pain?
Y N Do your jaw joints (TMJ) pop, click or make a grinding sound?
Y N Do you experience pain in your jaw joints?
Y N Are your teeth sensitive to hot, cold, sweets, or pressure?
Y N Have you had any periodontal (gum) treatments?
Y N Do your gums bleed, feel tender or irritated?
Y N Have you ever had or been evaluated for orthodontic treatment?
Y N Have you ever had a serious/difficult problem associated with any previous dental work?
Y N Do you have bad breath or has anyone ever told you that you have bad breath?
Y N Do you snore or do you feel tired even after a full nights sleep?

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.
____Fear of pain ____Lack of concern ____Cost of treatment ____Missing work time

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Please take 5 seconds to tell us how you **FIRST** learned about Firewheel Smiles? (Please check all that apply)

- ☐ Referral: Name of Individual: _____
- ☐ Drive By: On site signage
- ☐ Dental Insurance Website
- ☐ Internet
- ☐ Search Engine
- ☐ Postcard
- ☐ Letter (New to neighborhood)
- ☐ Dental News and Views
- ☐ Other: _____

Patient Name: _____

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Medical Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Y N Are you under a Physician's care now? If **YES,** please explain: _____
Y N Have you ever been hospitalized or had a major operation? If **YES,** please explain: _____
_____
Y N Have you ever had a serious head or neck injury? If **YES,** please explain: _____
Y N Are you taking any medications, pills, or drugs? _____
Y N Do you take, or have you taken, Phen-Fen or Redux? _____
Y N Are you on a special diet? _____
Y N Do you use tobacco? _____
Y N Do you use controlled substances? _____

Women: Are you ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other Please list: _____

Do you have, or have had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/ Fever Blisters	☐ Genital Herpes	☐ Kidney Problem	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature or Guardian if child: _____ **Date:** _____

Patient Name: _____

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Authorization for Release of Identifying Health Information

I authorize Firewheel Smiles to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released.
2. To whom may the informtion be released [name(s) or class(es) of recipients]
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).
4. Expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you wan to revoke your authorization, send us a written or electronic note telling us that your authrozation is revoked. Send this note to the office named on the top of this form.

When your helath information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature or Guardian if child: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have been given the opportunity to receive FIREWHEEL SMILES' Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by FIREWHEEL SMILES, my individual rights and the FIREWHEEL SMILES' legal duties with respect to my protected health information. These include, but are not limited to the following:

- A statement that FIREWHEEL SMILES is required by law to maintain the privacy of protected health information.
- A statement that they are required to follow the terms of the notice currently in effect.
- Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.
- A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.
- A description of uses and disclosures that are prohibited or limited by law.
- A description of disclosures that require my written authorization and how I may revoke authorization.
- My individual rights with respect to protected health information and how I can exercise those rights in relationship to:
    - The right to complain to FIREWHEEL SMILES and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.
    - The right to request restrictions of certain uses and disclosures of my protected health. However, I understand that FIREWHEEL SMILES does not have to agree to honor my requested restrictions.
    - The right to receive confidential communications of protected health information.
    - The right to request to amend protected health information.
    - The right to request an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from FIREWHEEL SMILES upon request.

I also understand the FIREWHEEL SMILES reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.

Signature: _____ Date: _____

Relationship to Patient (if signed by a personal representative of patient)_____

If you would like to authorize a person or persons to be able to talk about your treatment or account, please sign below.

My treatment and account status may be discussed with _____ (name)

_____ (relationship). _____ date