VIBRANT SMILES
Family & Cosmetic Dentistry

NEW PATIENT FORMS

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for ☐ Yourself ☐ Your Child

Patient Full Name_____ Social Security #_____

Birth Date_____ Age_____ ☐ Male ☐ Female

Address_____

City_____ State _____ Zip_____

Full Time Student ☐ Yes ☐ No School Name_____

Employer_____ Occupation_____

Previous Dentist_____ Previous Dentist Phone_____

Current Physician_____ Current Physician Phone_____

Whom may we thank for referring you?

2) TELEPHONE & EMAIL

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

In the event of an emergency, who should we contact? Name_____

Relationship_____ Home Phone_____ Work Phone_____

3) RESPONSIBLE PARTY

Who is responsible for this patient?

Full Name_____ Social Security #_____

Are you ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth Date_____ Age_____ ☐ Male ☐ Female

Address_____

City_____ State _____ Zip_____

Employer_____ Occupation_____

Home Phone_____ Work Phone_____

Medical History

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you been hospitalized or had a major operation?	Yes	No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	_____
Do you use controlled substances?	Yes	No	_____

Women: Are you :
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other:_____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Glaucoma	Yes	No	Mitral Valve	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Hay Fever	Yes	No	Prolapse	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Congenital Heart	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Ulcers	Yes	No
Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Venereal Disease	Yes	No
Convulsions			Heart Trouble/Disease			Psychiatric Care			Yellow Jaundice	Yes	No

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

Comments:_____

_____

_____

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DENTAL HISTORY

1. Reason for Visit / Main Concern? _____

2. Are there other conditions of which we should be aware? YES _____NO_____

If yes, please specify:_____

3. When did you last visit a dentist? _____What treatment was performed?_____

_____

5. Was the treatment completed? YES_____NO_____. Were dental x-rays taken? YES_____NO_____

7. Did you have a cleaning? YES_____ NO_____

8. Have you had gum (periodontal) treatment? YES_____ NO_____

9. Have you ever had prolonged bleeding after an extraction? YES _____ NO_____

If yes, please specify:_____

10. Have you had any problems with past dental treatment? YES_____ NO_____

If yes, please specify:_____

_____

11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES____NO___

If yes, please specify:_____

12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES_____ NO_____

If yes, please specify:_____

13. Do your gums bleed easily? YES_____ NO_____

14. Do you feel you have bad breath? YES_____NO_____

15. Are your teeth sensitive to hot or cold? YES_____ NO____

16. Would you like your teeth whiter? YES_____NO_____

17. Are you happy with your smile? YES_____ NO_____

If no, please explain:_____

Oral Cancer Screening Consent Form

Our office is continually seeking new technology to aide in providing you with access to the newest and most effective scientific screening and treatment. We now offer Velscope Vx, it is a new medical device that helps aid us in finding early signs of oral cancer in the mouth. **One American dies every hour from oral cancer.** Like most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol increase the risk, but more that 25% of people with oral cancer have no such lifestyle risk factors. In the past few years, scientists have found a connection between HPV and oral cancer. Oral cancer risks per age are as follows:

Increased risk: Patients ages 18-39 (especially if exposed to HPV)

High Risk: Patients 40 and older, tobacco users (any age, within 10 years)

Highest risk: Patients age 40 & older; tobacco and/or alcohol use; and/or previous history of oral cancer.

The exam has been recognized by the American Dental Association as a dental procedure; however this exam may not be covered by your insurance. **INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of the use of the Velscope Vx/or oral cancer screening. The fee(s) for this service has been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Dr. Rainford and/or all associates involved in rendering any services he/she deems necessary or advisable to treatment of my dental conditions. **The fee for this service is $25. Please sign below accepting or declining Screening.**

YES. I request that the clinician perform the Velscope Vx examination along with the standard oral cancer examination

_____ _____

Patient Signature Date

NO. I decline Velscope Vx examination at this time.

_____ _____

Patient Signature Date

Permission to Use Photograph

Subject: Before and After Dental Treatment Photograph **Location:** Vibrant Smiles Dental Care, Mableton, Ga.

I grant to Chea Rainford DMD, its representatives and employees the right to take treatment photographs of me and my mouth in connection with the above-identified subject. I authorize Chea Rainford DMD, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Chea Rainford DMD may use such photographs of me without my name and for any lawful purpose, including for example such purposes as teaching, illustration, continuing education, and Web content.

I have read and understand the above:

Signature _____Printed name _____

Address _____Date _____

Office Policies

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dentistry in a caring and enjoyable atmosphere. Below you will find information on our office policies. Please feel free to ask one of our staff members any questions you may have. We look forward to providing you with state of the art dental care.

Appointment Policy

We believe that you deserve exclusive, personalized time with the doctor and staff. Our office strives to see every patient at their appointed time. In order for us to do that, it is important that you arrive on time. **If you are late by 15 minutes or more, your appointment may take longer than scheduled.**

If you need to reschedule your appointment we ask that you call us one business day in advance so that we may offer the appointment time to another patient that may be waiting to get in. **Any missed or broken appointments without 24 hours' notice will incur a $35 cancellation fee.**

Insurance Filing

We file all claims forms electronically, provide postage for special claims and track the claims as courtesy to our Patients. Our office will accept assignment for only the primary insurance coverage, secondary insurance coverage must be paid to the patient. We make every effort to accurately estimate your benefits prior to your appointment, however, most insurance companies do not give an accurate estimate until the actual claim is received and processed. **The benefits we are given by the insurance company are an ESTIMATE ONLY and not a guarantee of payment.**

On the day of your appointment you will be asked to pay the portion that we estimate the insurance company will not pay based on your coverage then file the claim and the insurance portion will be paid directly to our office. If the insurance check is sent directly to you, then you will be asked to pay the entire portion at the time of treatment. **Any amount not covered by your insurance will be your responsibility. If there is a difference between your portion and the insurance company's payment, we will send you a statement for the balance.** Our office will file your insurance claim a maximum of two (2) times per appointment. If the claim is not paid by your insurance carrier within sixty (60) days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.

Payment Options

Our goal is to help remove the financial barriers so our patients can receive the dental care they need and desire. We accept cash, checks, Visa and MasterCard. We even offer treatment financing through Care Credit.

Please not that any account balances that reach 90 days past due will be turned over for collection. There will be a $30 service charge for all returned checks.

Patient Name_____ Date_____

Patient Signature_____

Vibrant Smiles Dental Care, PC.

*** You May Refuse to Sign This Acknowledgment***

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

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 acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)