Beautiful Smile, LLC

Charmen W. Douglas, DMD

Date_____

Patient's Name_____ Nickname_____

Date of Birth_____ Age _____Social Security No._____

If patient is a child, parent's name_____ Name of spouse_____

Street address _____Home Phone_____

City_____ State _____Zip code _____ Cell Phone _____

Patient's Employer_____ Work Phone _____

Work address_____

Email address _____

Number which is best to confirm your appointments_____ Preferred time for us to call_____

Person responsible for account_____Phone_____

Their address_____ Work phone_____

Their employer_____

Work Address _____

Employee's Social Security #_____ Employee's Date of Birth _ _____

Do you have Dental Insurance? Yes____ NO____ Do you have Secondary Insurance Yes_____ No_____

Primary Insurance company _____Their phone # _____

Subscriber's ID #_____Policy #_____ Group #_____

Second Subscriber's Name_____ Second Employer_____

Secondary Insurance Company_____ Their Phone#_____

Subscriber's ID #_____Policy #_____ Group #_____

Second Social Security # _____ Second date of birth_____

In case of Emergency, notify_____Relationship_____

Phone #_____ Referred to our office by _____

All fees associated with professional dental services are the guest/patient's responsibility. We will bill all third party insurance companies on your behalf. If the third party insurance company does not respond to the treatment claim within 30 days the patient will be notified and payment from the patient will be expected within 15 days of notification. Patient will be refunded when and if the third party responses to the claim at a later date.

Signature of patient, parent, or guardian_____ Date_____

DENTAL HISTORY

It is important we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail.
Please answer all questions by checking or circling "Yes" or "No" and fill in all blank spaces where indicated if applicable.
Thank you.

Patient's name_____Date_____

Previous Dentist's name_____Telephone_____

Address _____

Date of last visit _____

Reason for today's visit _____

Have you ever had any serious trouble associated with previous dental treatment? _____

_____

Does dental treatment make you nervous? No_____ Slightly_____ Moderately_____ Extremely_____

Have you ever had nitrous oxide (laughing gas) during dental treatment? Yes_____ No_____

Do you wish to have nitrous oxide? Yes_____ No_____

Do you wish to replace any missing teeth? Yes_____ No_____

Do you want to keep your own teeth to avoid dentures? Yes_____ No_____

Are you happy with your smile? Yes_____ No_____

Do you have or have you had any of the following:

No Yes…Bleeding or sore gums?
No Yes…Sensitivity to hot, cold, or sweet?
No Yes…History of fever blisters or cold sores?
No Yes…Recurrent canker sores, mouth ulcers, or oral herpes infection?
No Yes…Excessive bleeding after extractions or surgery?
No Yes…Periodontal (gum) treatment?
No Yes…Orthodontic treatment (braces)?
No Yes…TMJ treatment?
No Yes…Sleep disorders?
No Yes…Neck Pain?
No Yes…Migraines?
No Yes…frequent visits to a Chiropractor?
No Yes…Osteoporosis?
No Yes…Bisphosphonate Therapy?

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of patient, parent, or guardian_____ Date_____

Update_____ Update_____ Update_____

Beautiful Smile, LLC
Smile Evaluation

Using a full face mirror, carefully examine your smile. Then answer the following questions. This simple questionnaire will help us to assist you in obtaining your dream smile.

1. Do you like the appearance of your teeth? □Yes □ No
   If *No*, explain: _____
   _____
2. Do you like the color of your teeth? □Yes □ No
   If *No*, explain: _____
   _____
3. Do you like the shape of your teeth? □Yes □ No
   If *No*, explain: _____
   _____
4. Are your teeth in alignment (straight)? □Yes □ No
   If *No*, explain: _____
   _____
5. Do you have any spaces that you don't like? □Yes □ No
   If *Yes*, explain: _____
   _____
6. Do you have any teeth that are worn down? □Yes □ No
   If *Yes*, explain: _____
   _____
7. Do you have any old fillings or dental work that you do not like? □Yes □ No
   If *Yes*, explain: _____
   _____
8. Are any of your teeth… □ Missing □ Chipped □ Protruding □ Hidden?
   Please explain: _____
   _____
9. What would you like to change the most?
   Please explain: _____
   _____
10. How would you like your teeth to look in 5 to 10 years?
    Please explain: _____
    _____

Patient Name: _____ Date: _____

Beautiful Smile, LLC
Charmen W. Douglas, DMD
146 Haddonfield-Berlin Road Suite 302, Gibbsboro, NJ 08026 856-346-8900

Health History

Please answer all questions by circling "Yes" or "No" and fill in all blank spaces when indicated if applicable.

Patient's Name_____ Date_____

Physician's Name_____ Telephone _____

Physician's Address_____ Date of last visit_____

No Yes … Has there been any change in your general health within the past year?
If yes, what is the change? _____
_____

No Yes … Are you now under a physician's care? If yes, what condition is being treated? _____
_____

No Yes …Have you ever been hospitalized or had a serious illness during the past 5 years? If Yes, what was the problem? _____
_____

No Yes … Do you use tobacco in any form? _____

No Yes … Do you consume alcoholic beverages? _____

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

No Yes … Tire easily, weakness?
No Yes … Marked weight change?
No Yes … Night sweats?
No Yes … Persistent fever?
No Yes … Persistent swollen glands?
No Yes … Sinus problems?
No Yes … Seizures or convulsions?
No Yes … Psychiatric treatment?
No Yes … Shortness of breath when you lie down?
No Yes … Asthma, hay fever, difficulty breathing?
No Yes … A persistent cough, or coughing up blood?
No Yes … Tuberculosis or emphysema?
No Yes … Diabetes?
No Yes … Frequent urination (more than 6 times a day)?
No Yes … Excessive thirst?
No Yes … Thyroid disease?
No Yes … Rheumatic fever or rheumatic heart disease?
No Yes … Heart murmur, mitral valve prolapse, or congenital heart disease?
No Yes … Heart trouble, heart attack, stroke, pace maker, or prosthetic heart valve?
No Yes … Shortness of breath or chest pain after mild exertion (angina)?
No Yes … High blood pressure?
No Yes … Arthritis?
No Yes … Do you have any artificial bones or joints (prosthesis) implanted?
No Yes … Hepatitis, jaundice, or liver disease? If yes, which type A___ B___ Non A / Non B____
No Yes …Stomach ulcers?
No Yes … Kidney trouble or renal dialysis?

No Yes … Venereal disease, gonorrhea, syphilis?
No Yes … Do you have blood in your urine or urethral discharge?
No Yes … Do you have any blood or bleeding disorders (like anemia)?
No Yes … Do you bleed excessively after you are cut or bruise easily?
No Yes … Have you ever required a blood transfusion?
No Yes … Have you ever been denied permission to give blood?
No Yes … Cancer? If yes, where?_____
No Yes … Have you had surgery or radiation (x-ray) treatment for tumor, growth, cancer, or other condition of the head, neck, or mouth? If yes, where? _____
No Yes … Do you have any hearing, visual problems, or other disabilities which we should consider in planning your dental care (eg. glaucoma)? If yes, what?_____
No Yes … Have you been in contact with any individual having hepatitis, tuberculosis, or AIDS?
No Yes … Do you have AIDS, ARC or positive antibody test for HTLV-III?
No Yes … Family History of Heart disease, diabetes, or immunologic disease? If yes, what_____
_____

Have you taken any of the following medications in the past six months:

No Yes … Anticoagulants (blood thinners)?
No Yes … Blood pressure medication or water pills?
No Yes … Cortisone or steroids?
No Yes … Valium, Librium, or tranquilizers?
No Yes … Insulin or pills for diabetes?
No Yes … Digitalis or drugs for a heart problem?
No Yes … Nitroglycerin?
No Yes … Aspirin?
No Yes … Dilantin?
No Yes … Birth control pills?
No Yes … Recreational drugs?
No Yes … Other medications and dosage?_____
_____

Are you allergic or have had any reaction to:

No Yes … Novocaine or dental anesthetics? If yes, what? _____
No Yes … Penicillin, erythromycin, or other antibiotics? If yes, what? _____
_____
No Yes … Aspirin?
No Yes … Codeine or other narcotic? If yes, what? _____
No Yes … Other allergies? _____

No Yes … Women: Are you pregnant or anticipating pregnancy in the near future?

Do you have any disease, condition, or problem not listed above that you think I should know about? Please describe. _____
_____

To the best of my knowledge, all the preceding answers are true and correct.

Signature of patient, parent, or guardian _____date_____

B.P____/____ Pulse _____

Aesthetic Dental Care

Charmen Douglas, DMD
146 Haddonfield-Berlin Road, Suite 302
Gibbsboro, NJ 08026
856-346-8900

Patients are responsible for their fees the same day the services are rendered, unless specific arrangements are made in advance with our staff. Our office accepts cash, checks, and all major credit cards.

Patients with insurance coverage will be responsible for their co-payment and deductible at the time of service. We will submit to your insurance company on your behalf.

We do offer financing options upon approval. Please feel free to ask our staff for more information prior to scheduling treatment.

All fees associated with professional dental services are the guest/patient responsibility. If the third party insurance company does not respond to the treatment claim with in 30 days the patient will be notified and payment from the patient will be expected with in 15 of notification. Patent will be refunded when and if the third party responses to the claim at a later date.

If you have additional questions concerning our financial policy please feel free to ask our staff.

Signature _____date _____

HIPAA PRIVACY FORM 3

Consent for Use and Disclosure of Health Information

USE OF THIS FORM IS OPTIONAL

Purpose: In cases where Charmen W. Douglas DMD has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

AESTHETIC DENTAL CARE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Cell Number: _____ Social Security Number: _____

What phone number is best to call to confirm your appointment? _____

May we call you at work? _____

May we leave a message at home with family member or on a answering machine? _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Angie Alpha 146 Haddonfield-Berlin RD #302 Gibbsboro NJ 08026

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).