

# Palm Beach Smiles

Aesthetic Dentistry by Michael I. Barr, D.D.S.

650 W. Boynton Beach Blvd., Suite 1

Boynton Beach, FL 33426

561-736-2377

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## Financial Arrangements

### All patients, please read the following...

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash and personal checks are accepted. If an extended payment plan is desired, please ask us about the CareCredit program. MasterCard and VISA credit card payment are also welcome. For charges of \$500 or greater, a 5% courtesy will be extended for full cash (or check) payment in advance. If you have any questions, please feel free to ask.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

### If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

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Print Name

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Signature & Date

# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Why are you now seeking dental treatment? \_\_\_\_\_

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now?..... Yes No
2. Are you now under the care of a physician? ..... Yes No  
If so, what is the condition being treated? \_\_\_\_\_
3. Have you ever been hospitalized or had a serious illness?..... Yes No  
If yes, explain \_\_\_\_\_
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? Yes No
5. (Women) Are you pregnant? If so, give due date \_\_\_\_\_ Yes No
6. Do you use tobacco in any form? If yes, how much? \_\_\_\_\_ Yes No
7. Do you use alcoholic beverages (more than 2 drinks per day)? ..... Yes No
8. Do you have or have you ever had any of the following?

## GENERAL

Tire easily, weakness Yes No  
 Marked weight change Yes No  
 Night sweats Yes No  
 Persistent fever Yes No

## SKIN

Eruptions (rash) hives Yes No  
 Change in skin color Yes No

## EYES

Visual Change Yes No  
 Glaucoma Yes No

## EARS

Loss of hearing Yes No  
 Ringing in ears Yes No

## NOSE

Frequent nosebleeds Yes No  
 Sinus problems Yes No

## THROAT

Soreness/hoarseness Yes No

## NERVOUS SYSTEM

Stroke Yes No  
 Headaches Yes No  
 Convulsions/epilepsy Yes No  
 Numbness/tingling Yes No  
 Dizziness/fainting Yes No  
 Psychiatric treatment Yes No

## RESPIRATORY

Tuberculosis Yes No  
 Emphysema Yes No

Asthma/hay fever Yes No  
 Persistent cough Yes No  
 Sputum production (Phlegm) Yes No  
 Cough up bloody sputum Yes No  
 Difficulty breathing lying down Yes No

## ENDOCRINE

Diabetes Yes No  
 Family history of diabetes Yes No  
 Thyroid condition/goiter Yes No  
 Other \_\_\_\_\_

## HEART/BLOOD VESSELS

Rheumatic Fever Yes No  
 Heart Murmur Yes No  
 Chest pain/discomfort Yes No  
 Heart attack/trouble Yes No  
 Shortness of breath Yes No  
 High blood pressure Yes No  
 Congenital heart disease Yes No  
 Artificial heart valve Yes No  
 Pacemaker Yes No  
 Heart surgery Yes No  
 Other \_\_\_\_\_

## BONE/MUSCLES

Arthritis/rheumatism Yes No  
 Artificial joints Yes No

## DIGESTIVE SYSTEM

Hepatitis Yes No  
 Jaundice Yes No  
 Ulcers Yes No  
 Change in appetite Yes No  
 Black, bloody or pale stools Yes No

## URINARY

Kidney disease Yes No  
 Increase in frequency of urination (night) Yes No  
 Burning on urination Yes No  
 Urethral discharge Yes No  
 Bloody urine Yes No  
 Venereal disease Yes No

## BLOOD

Bruise easily Yes No  
 Anemia Yes No  
 Blood transfusion Yes No

## OTHER

Radiation therapy Yes No  
 Tumors or growths Yes No  
 Cancer Yes No  
 AIDS Yes No

Please complete second page

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/other antibiotics	Yes	No	Other allergies _____		

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/allergy drugs/ cold remedies	Yes	No	Aspirin	Yes	No
			Other medication _____		

If yes to any of the above, list **name** of medication and **dosage** below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_

12. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

13. Have you ever had any serious trouble associated with previous dental treatment? Yes No  
If so, explain \_\_\_\_\_

14. Does dental treatment make you nervous? No Slightly Moderately Extremely

15. Date of last dental visit \_\_\_\_\_

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No  
If so, when? \_\_\_\_\_

17. Do you have or have you ever had any of the following?

**MOUTH**

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blister, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

**TEETH**

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No

**ORAL HYGIENE**

Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No
Other _____		

How often do you brush \_\_\_\_\_  
Brush is: soft medium hard

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

If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT REGISTRATION**

Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience as possible.

Date
Patient Name
Address
City State Zip
Best way to contact you: H W C Phone E-mail Text Message
Home Phone No.
Work Phone No.
Cellular Phone No.
E-mail Address
Birth date Age Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security Number
Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Employer Position
School

The best time for you for appointments are at: _____ AM/PM
The best day of the week is: M T W T R (Circle one or more)
Who make we thank for your referring you:
<input type="checkbox"/> Friend's Name
<input type="checkbox"/> Sign
<input type="checkbox"/> Website / Internet Search
<input type="checkbox"/> Newspaper
<input type="checkbox"/> Television
<input type="checkbox"/> Other
Emergency Contact Information:
Name
Relationship
Phone Number
Address
City State Zip

Responsible Party
Address
City State Zip
Responsible Party Social Security Number

<b>DENTAL INSURANCE</b>
<b>PRIMARY DENTAL CARRIER</b>
Insurance Co.
Subscriber Birth date
Subscriber
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

<b>SECONDARY DENTAL CARRIER</b>
Insurance Co.
Subscriber
Subscriber Birth date
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

**CONSENT FOR TREATMENT**

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of \_\_\_\_\_'s dental needs.

(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

\_\_\_\_\_  
Patient Date

\_\_\_\_\_  
Parent of Guardian Relationship

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## Smile Survey

Our office is conducting a survey of our patients. If you would kindly answer a few questions below, it would be greatly appreciated. 😊

How do you feel about your smile?

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If you could change anything about your smile, what would it be? (If you had a magic wand!)

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Is there anything that would keep you from improving your smile? If so, please explain.

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Are you familiar with how today's dentistry can enhance your smile? **Yes / No**

Would you like to learn more about how you can improve your smile? **Yes / No**

Your name: \_\_\_\_\_

Thank You! 😊