Welcome to Springfield Healthy Smiles!

First Name ____________ Middle Initial___________ Last Name ______________

Today's Date : _________________________________ DOB________ Sex: M F

Phone # ________________ SSN ___________________________________

Email ___________________________ Marital Status ____________________

Address ____

City ___________ State ______________ Zip Code ______________________

Employer ____________________ Occupation___________________________

Emergency Contact

First Name ________________ Last Name______________________________

Phone Number______________________Relationship to patient________________

Insurance Information

Insurance Company Name ____________ Insurance Phone # ____________________

Subscriber Name __________________Subscriber DOB ______________________

Group #__________________________ID#__________________________

Address ______________________Subscriber Relationship To Patient _____________

Secondary Insurance

Insurance Company Name ____________ Insurance Phone # ____________________

Subscriber Name __________________Subscriber DOB ______________________

Group #__________________________ID#__________________________

Address ______________________Subscriber Relationship To Patient _____________

Medical

Primary Physician ______________________________ Last Visit __________________________

Office Number _________________ Office Address _____________________________________

Medical History

	YES	NO	SPECIFY
Are you Under any Medical Treatments now?	☐	☐	
Have you ever been hospitalized?	☐	☐	
Are you taking any prescription or non prescription medications?	☐	☐	
Do you use tobacco?	☐	☐	
Do you use Alcohol?	☐	☐	
Do you use any illegal substance?	☐	☐	
Do you bleed easily?	☐	☐	
Are you allergic to any medication?	☐	☐	

Please list any allergies you may have such as latex, Amoxicillin , Penicillin etc.

____

Have you had any reaction to the following:

	YES	NO
Local Anesthetics	☐	☐
Barbiturates	☐	☐
Aspirin	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Sulfa Drugs	☐	☐

Women only:

	YES	NO
Are you pregnant or think you may be pregnant? If yes , Wks____________ Due date_______________	☐	☐
Are you nursing?	☐	☐
Are you taking Birth Control?	☐	☐

	YES	NO
Are you taking any hormonal replacement therapies?	☐	☐

Do you have or had any of the following?

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Frequently Tired	☐	☐
Heart Attack	☐	☐	Anemia	☐	☐
Stomach Issues	☐	☐	STD/HIV	☐	☐
Fainting/Seizures	☐	☐	Cancer	☐	☐
Asthma	☐	☐	Cardiac Pacemaker	☐	☐
Low Blood Pressure	☐	☐	Kidney Disease	☐	☐
Epilepsy/Convulsions	☐	☐	Heart Murmur	☐	☐
Rheumatic Fever	☐	☐	Joint or hip replacement	☐	☐
Rheumatic Arthritis	☐	☐	Chest Pain	☐	☐
Respiratory Problems	☐	☐	Glaucoma	☐	☐
Hay Fever	☐	☐	Radiation Therapy	☐	☐
Tuberculosis	☐	☐	Recent weight loss	☐	☐
Trouble Sleeping	☐	☐	Thyroid Problems	☐	☐

Other (please specify):____

Patient Dental History

	YES	NO
Do your gums bleed when brushing and flossing?	☐	☐
Are you sensitive to hot or cold liquids or Foods?	☐	☐
Are your teeth sensitive to sweet/ sour liquids or foods?	☐	☐
Do you feel any pain in your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any neck or Jaw injuries?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐

Have you had any orthodontic work? ☐ ☐

Have you had any of the following:

	YES	NO
Clicking of the jaw?	☐	☐
Difficulty in chewing?	☐	☐
Pain in ears or face?	☐	☐
Difficulty in opening and closing of the mouth?	☐	☐

Other (please specify): ____

I certify that I have read and understood the above information. I have correctly answered the above information to the best of my knowledge for myself or for the patient named below (If patient is a minor).

I understand that providing incorrect information can be dangerous to my health or the patient named below (If the patient is a minor). I will also notify Springfield Healthy Smiles PLLC and Dr. Farinaz Niroumand, should any of the above listed medical or dental information change.

Patient Signature:____Date:________________

Parent Signature (If patient is a minor)____

Patient/Parent/Subscriber Authorization Statement:

I hereby authorize Springfield Healthy Smiles PLLC and Dr. Farinaz Niroumand (Provider) to provide dental services to me and my dependents and children and apply my benefits on my behalf for covered services rendered. I request that the payments from my insurance company be made to the above named corporation and/or provider(s). I certify that the information that I have provided above is correct and further authorize the release of any necessary information including medical, dental and insurance coverage information to my insurance company in order to determine my insurance benefits to which I may be entitled. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as the original, this authorization may be revoked at any time in writing. I understand and agree that (regardless of my dental insurance status or coverage), I am **ultimately** responsible for the balance on my account and my dependents for any dental services rendered. **If my account becomes past due I agree to pay all costs of collections and litigations if any.** I have read this entire sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge and I will notify Springfield Healthy Smiles PLLC of any changes in my status or the above information.

Patient Signature:____Date:________________

Parent Signature (If patient is a minor)____

Authorization for use/disclosure of medical records

I consent to and authorize my healthcare provider, Springfield Healthy Smiles PLLC , to use or disclose my medical records to the following:

Name ______________________________Relationship_______________________________________

Name______________________________Relationship_______________________________________

Acknowledgement of receipt of Notice of Privacy Practice

You may refuse to sign this Acknowledgment

I understand and have received a copy of Springfield Healthy Smiles PLLC notice of Privacy Practice.

Patient Signature:____Date:_________________

Parent Signature (If patient is a minor)____

Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- other

Name of office staff:_______________________________________Date_________________________